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ABSTRACT

this monograph presents the proceedings of a symposium on early childhood special education. The proceedings stress: (1) the importance of a family-centered approach in early intervention; (2) the need for more parents' participation; and (3) the value of continuity and coordination in service provision. After the text of a brief opening speech by Lady Wilson, texts of the following plenary session speeches are provided (in both English and Chinese): "Recent Trends in Early Intervention" (M. J. Guralnick); "Early Identification, Assessment and Placement" (Rose Mak); "Parents' Roles and Involvement in the Training of Handicapped Children" (Joseph Lau); "Policy and Current Trends of Special Education in Hong Kong" (Ruth Lau); "Autism: Current Concepts, Research Findings and Implications for Services" (M. Rutter); "The Management of Autism in Hong Kong--Challenges and Directions" (C. K. Wong); "A Parent's Experience in Training Autistic Children" (L. C. Fung); and "Suggestions for Developing Services for Autistic Persons" (Wan Sing hin). Workshops on the following topics are briefly summarized: sharing of experience in training autistic children; the implications of categorization versus noncategorization in the training of handicapped children; prevention and management of behavior problems; helping parents of handicapped children; teaching methods and curriculum design in integrated/special preschool settings; and linkages between child care centers and special schools to foster child and parental adjustment. A final sharing session looked at major speakers' impressions of services for preschool handicapped children in Hong Kong. (DB)

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邁向九十年代的特殊幼兒服務

WORKING WITH YOUNG HANDICAPPED CHILDREN – THE WAY AHEAD

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PROCEEDINGS

NOVEMBER 17th – 18th 1989

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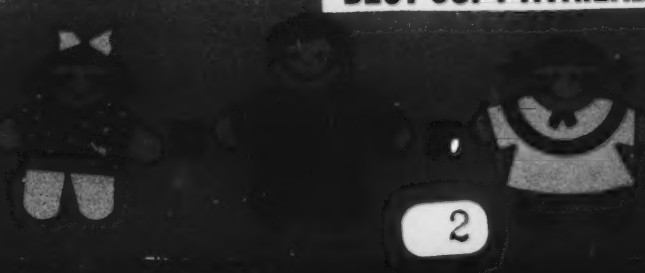

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FOREWORD

The symposium held on the 17 & 18 November 1989 marked the climax of our 25th anniversary celebrations. It was well attended by over 600 paediatricians, psychiatrists, psychologists, paramedical professionals, social workers, teachers, child care workers and parents. The event was particularly honoured by Lady Wilson, our patron, who officiated the opening ceremony.

In this symposium, we are much privileged to have had Professor M.J. Guralnick and Professor M. Rutter, two internationally famous experts, to be the keynote speakers. Appreciation should also go to those local professionals and parents who had kindly shared with us their insights and experiences in various plenary sessions and workshops.

When compared with those advanced countries, early childhood special education in Hong Kong is still in a state of infancy. The training for autistic children, in particular, has won increasing concern only in the past few years. For a long time, professionals and field workers have expressed the need for more stimulation and better input for the improvement of our services.

This symposium was organized to cater for this need. Basically it has two major objectives: first, to keep the participants informed of the recent concepts and development in early intervention programmes as well as the training for autistic children; second, to provide a forum for professional sharing among those who are working in the field. As a result of sharing and discussions, the symposium has successfully aroused the participants' concern to several issues that have direct bearings on the future development of services for pre-school handicapped children. These issues include:

(a) the importance of adopting a family-centered approach in early intervention;
(b) the need for more parents' participation;
(c) the significance of having continuity and co-ordination in the provision of services.

With reference to the contemporary models of service delivery and the outcomes of research studies, a list of recommendations has been included in this proceedings, which, I hope, would serve as an important blueprint for formulating plans for children with special needs in the years ahead.

Last but not the least, on behalf of the society, I would like to extend my heartfelt thanks to members of the organizing committee for their dedication, the time and energy they put into organising this function.

Mrs. Agnes Yeung
Chairman
Heep Hong Society

序

本會為慶祝成立廿五週年，安排了一連串活動。其中的壓軸項目，是於一九八九年十一月十七及十八日所舉辦的「邁向九十年代的特殊幼兒服務」專題研討會。是次研討會的參加者共六百多人，包括了兒科醫生、心理學家、治療師、社會工作員、教師、幼兒工作員及家長等。而本會贊助人港督衛奕信爵士夫人亦應邀蒞臨為這次研討會主持開幕典禮，使整個研討會生色不少。

本會今次十分榮幸，邀請了兩位蜚聲國際學者：Professor M.J. Guralnick 和 Professor M. Rutter 為該研討會作專題演講。此外，本會也非常感謝多位本港的專業人員及家長在各回應短講或分組研習中講解有關知識及分享經驗。

香港的特殊幼兒教育服務，相對於其他先進國家來說，仍屬雛型階段。以訓練自閉症兒童為例，也是近年才日漸受到社會人士的關注。一直以來，專業人士和特殊幼兒工作員都表示了他們需要更多有關方面的知識和激勵，來改善目前學前弱能／弱智兒童的服務。

本會考慮到這方面的需要，所以主辦了這次專題研討會。以達到兩項目的：第一，使參加者得知最新有關早期介入服務的概念和發展，以及訓練自閉症兒童的具體技巧；第二，為從事特殊幼兒服務的人士提供一個表達意見和經驗交流的機會。透過討論和分享，是次研討會成功地喚醒了參加者關注到以下幾項有關特殊幼兒服務的要點，它們包括：

（一）以家庭為重心來推行早期介入服務的重要性；

（二）家長積極參與的需要性；

（三）在提供服務方面，統籌和持續服務的關鍵性。

本會就著現行的服務模式和有關研究結果，歸納了一系列的建議，在這專題論文滙編中發表，以供各位參考。希望這些建議能夠成為未來釐訂特殊幼兒服務計劃的藍圖。

最後，本人謹代表協康會對這次研討會「籌備委員會」的每位成員，在籌備期間所付出的時間、心思和勞苦，致以衷心的感謝。

楊羅觀翠
協康會主席

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PROGRAMME

November 17, 1989
(Friday)
Plenary Session I
2:30p.m. - 5:45p.m.

Welcoming Remarks
Mrs. Agnes Yeung
Chairman, Heep Hong Society

Opening Speech
Lady Wilson

Moderator of Plenary Session
Mrs. Agnes Yeung

Keynote Speech
"Recent Trends in Early Intervention"
Speaker: Professor M.J. Guralnick

Response to Keynote Speech
(1) "Early Identification, Assessment and Placement"
Speaker: Dr. Rose Mak

(2) "Parents's Roles and Involvement in the Training of Handicapped Children"
Speaker: Mr. Joseph Lau

(3) "Policy and Current Trends of Special Education in Hong Kong"
Speaker: Mrs. Ruth Lau

Open Discussion

November 18, 1989
(Saturday)
Plenary Session II
9:00a.m. - 12:30p.m.

Welcoming Remarks
Mrs. Agnes Yeung
Chairman, Heep Hong Society

Moderator of Plenary Session
Mr. F.C. Tang
Adviser, Heep Hong Society

Keynote Speech
"Autism: Current Concepts, Research Findings and Implications for Services"
Speaker: Professor M. Rutter

Response to Keynote Speech
(1) "A Psychiatrist's Perspective"
Speaker: Dr. C.K. Wong

(2) "A Parent's Experience in Training Autistic Children"
Speaker: Mrs. L.C. Fung

(3) "Comment on Services for Autistic Children in Hong Kong"
Speaker: Mr. Wan Sing-hin

Open Discussion

Concurrent Workshops
2:00p.m. - 3:30p.m.

(1) "Sharing of Experience in Training Autistic Children"
Moderator: Dr. Christina Cheng
Speakers: Miss Ophelia Kan
Miss Francis Yip
Miss Kitty De La Rosa
Miss Ivy Tam
Rapporteur: Miss Christina Kan

(2) "Categorization versus Non-Categorization — its Implications on the Training of Handicapped Children"
Moderator: Professor M.J. Guralnick
Speakers: Dr. L.R. Jasper
Mrs. Wyman Chan
Miss Lee Tsor-kiu
Rapporteur: Dr. Sylvia Opper

(3) "Prevention and Management of Behavioural Problems in Handicapped Children"
Moderator: Professor M. Rutter
Speakers: Dr. Sylvia Chen
Miss Agnes Ma
Dr. Lyn Gow
Rapporteur: Mrs. Sandra Ho

(4) "How to Help Parents with Handicapped Children"
Moderator and Rapporteur: Mrs. Agnes Wong
Speaker: Dr. C.K. Wong

(5) "Use of Normal Teaching Methods and Curriculum Design in Integrated/Special Pre-school Setting"
Moderator and Rapporteur: Miss Sansan Ching
Speakers: Mrs. Bessie Pang
Mrs. Alice Lai

(6) "From Special Child Care Centres to Special Schools — its linage and the Adjustment of the Children and their Families"
Moderator and Rapporteur: Mrs. Anna Leung
Speakers: Mrs. Y.W. Chow
Mr. John Wong
Miss C.H. Tsang

Rounding Up Session
3:45p.m. - 5:00p.m.

Moderator of Rounding Up Session
Mr. F.C. Tang

Brief Reports on the Workshops
Rapporteurs of Workshops

Sharing Session
"Sharing the Impression of the Services for Pre-school Handicapped Children in Hong Kong"
Speakers: Professor M.J. Guralnick
Professor M. Rutter

Open Discussion

OPENING SPEECH

Lady Wilson

Mrs Yeung, Professor Rutter, Professor Guralnick, ladies and gentlemen,

As patron of Heep Hong Society for Handicapped Children, may I first of all welcome you to this symposium on "Working with Young Handicapped Children — the Way Ahead". This symposium is the climax of the Society's Jubilee Year Celebration. I would also like to take this opportunity to congratulate the staff and committee members of the Society, for the immense amount of effort and care they have taken to organize this and other events.

Concern for the development and care of young children has been increasing over the last two decades. The International Conference on Early Education and Development, held in Hong Kong this summer, with child care workers, teachers, psychologists and others from all over the world, was one exciting example of this concern.

Besides the interest in early education of normal children, there is increasing concern and awareness in many countries now, that early intervention with children whose development is impeded by their mental and/or physical handicaps is necessary. It has clearly been established that early diagnosis can help to prevent deterioration, and give a far better chance to the child of developing its full potential.

It is vital to recognize that within the label of "handicapped", there is much diversity in the nature and extent of handicaps. It is therefore understandable that the provision of appropriate services to these children is no simple matter. No single discipline, be it physicians, psychologists, educators, teachers, or even parents themselves, can claim adequacy in handling these special children on their own. While the professionals might have the scientific or professional knowledge at hand, they lack the parents' chances of sustained observation and interaction with the children. It is only through sharing of experiences, and cooperation of all these concerned parties, that wisdom in the field can be pooled to attain the best results. Chances of cross-cultural and cross-country exchanges such as this conference, can further facilitate the process of mutual understanding and development in this field.

I am delighted to address you all during this important event, that aims at sharing knowledge of current trends in early intervention, parental involvement, and multi-disciplinary approach. In this symposium, it is a very special pleasure to have two internationally famous scholars with us — Professor Guralnick of the University of Washington, and Professor Rutter of the University of London, to give us their insights into early childhood special education and the training of autistic children. I must tell you, although he will certainly not remember, that when I was running my own school in London, I tried to attend as many of Professor Rutter's seminars as I could, and insisted that my teachers read his work. I remember one symposium, in particular, where he helped me no end in the work I was doing in a child guidance clinic. We are lucky to have him with us today. It is also good to have local professionals and parents, to share with us their valuable experiences. By pooling all this knowledge, I am sure that you will arrive at helpful suggestions, and better collaboration in the planning of programmes for young handicapped children.

In Hong Kong, the Government and the voluntary sector have been working closely together to promote services for pre-school handicapped children. This kind of co-operation is something we are proud of. The

Working Party on Pre-school Care, Education and Training, formed in 1982 is an indication of this, after which a comprehensive review of the services was conducted, and many valuable recommendations and guidelines were laid. In fact, most of the recommendations have been implemented since 1987. There is however still much to be done.

There clearly is a need for early training, and services should be provided whenever this need is identified, as early as possible. I was glad to learn that with the anticipated expansion rate of the new service units, we hope to have sufficient places for children in the Special Child Care Centres and Early Education and Training Centres by 1991 or 1992 at the latest. Social Welfare Department is also drawing up plans to provide services for the mildly handicapped children waiting for placement in integrated programmes in child care centres. Heep Hong Society itself is planning a Parent Education and Resource Centre to enable parents to learn more, so that they can help their children more effectively.

Now that we are moving closer to meeting basic needs, it is time we devoted our efforts to improving the quality of our work. I am well aware, as I said, that the recommendations of the Working Party have provided useful guidelines for services and that most of the suggestions have been acted upon. Pre-school rehabilitation services are growing fast. I sincerely hope, however, that the ideas which came out of the Working Party can be developed further. We must continue to think of new ideas, and learn from what has been done in other countries.

Finally, may I wish you all a most successful conference. This is a wonderful chance for all of us to learn.

致　辭

總督衞奕信爵士夫人

楊主席、Rutter 教授、Guralnick 教授、各位來賓：

作爲協康會的贊助人，我首先歡迎各位出席「邁向九十年代的特殊幼兒服務」專題研討會。這個研討會是協康會二十五周年慶典活動的高潮。我亦想藉這個機會，向該會的工作人員和執行委員致意，他們爲了籌辦這個研討會和其他活動，不辭勞若，費盡心思。

在過去二十年，幼兒的發展和照顧，日益備受關注。今年夏天在香港舉行的嬰幼教育與發展國際研討會，便是這方面一個令人鼓舞的例子。這個研討會吸引了世界各地的兒童護理工作者、教師、心理學家和其他人士參加。

除了對正常兒童的早期教育感興趣外，很多國家現在亦逐漸關注和認識到對因弱智或弱能以致發展受到影響的兒童及早予以協助的需要。現時經已明確證實，及早作出診斷，便可避免這些兒童的情況惡化，並可使他們有更大的機會盡量發展潛能。

我們必須明白到，「弱能」和「弱智」包括多種不同性質和不同程度的身心阻礙。因此，要爲這些兒童提供適當服務，並不是容易的工作，這點是可以理解的。無論是醫生、心理學家、教育工作者、教師以至家長，都不能自誇可單獨爲這些有特殊需要的兒童，提供足夠的照顧。專業人士雖然具有科學或專業知識，但他們却缺乏像兒童的父母所具備的機會，與孩子作長時間的接觸，觀察他們的情況。只有在各有關人士共同合作和交流經驗底下，才能在照顧特殊幼兒方面集思廣益，達致最佳效果。舉行例如今天的研討會，讓來自不同文化背景和不同國家的代表交流意見，實有助進一步加深彼此對特殊幼兒服務的認識，並可促進這方面的工作發展。

我很高興能夠在這樣重要的聚會裏和各位講話。這次研討會的目的，是讓各位分享到對特殊幼兒提供及早協助這方面的最新發展、以及父母參與和提供綜合服務等問題的知識。此外，我們亦十分榮幸，邀請到兩位國際知名學者－華盛頓大學的 Guralnick 教授和倫敦大學的 Rutter 教授－與我們分享他們對幼兒特殊教育，和訓練自閉症兒童的精辟見解。雖然 Rutter 教授可能已經忘記了，但我很想告訴各位的是，當我在倫敦辦學的時候，凡是 Rutter 教授主持的研討會，我必定會設法參加，並且要求在我學校任教的教師，閱讀他的著作。最令我難忘的是，在某一個研討會上，他爲我提供了指導，對我當時在一所兒童心理輔導中心的工作起了很大的幫助。今天我們能夠邀請到他出席，真是十分榮幸。同時，也很難得有本港的專業人士和家長出席，與我們分享他們寶貴的經驗。我相信在大家集思廣益，共同參與的情況下，必定能達致有用的建議，和在安排特殊幼兒的服務計劃時，能夠收到更好的合作效果。

在香港，政府和志願機構一直緊密合作，推廣特殊幼兒的學前服務。這種合作值得我們深感自豪。一九八二年成立的學前照顧、教育及訓練工作小組，正是這種合作的例子。該工作小組成立後，即全面檢討這方面的服務，並且提出多項寶貴建議和制訂指引。事實上，工作小組大部分的建議已自一九八七年起先後付諸實施，不過，仍待努力的地方還有很多。

及早爲特殊幼兒提供訓練確實是必須的，而在這種需要被確認後能夠愈早提供服務愈好。我很高興知道，按目前新服務單位預計的擴展率，我們可望最遲在一九九一年，或一九九二年，能在各特殊幼兒中心和學前訓練中心提供足夠的名額，給有需要的兒童。社會福利署亦正制訂計劃，爲等待進入兼收弱能兒童幼兒中心的輕度弱能兒童，提供服務。另一方面，協康會正計劃成立一個家長教育及資料中心，藉以豐富家長的知識，讓他們能夠更有效地協助子女成長。

在我們大致上已能滿足基本需要的時候，我們就應致力改善服務的質素。正如我剛才所說，我清楚知道工作小組的建議，已爲學前特殊幼兒服務提供實貴指引，而大部分建議亦已實施。學前康復服務亦有迅速的發展。我懇切希望工作小組的各項構思能夠獲得進一步發展。我們必須繼續發展新的意念，並同時向其他國家的經驗借鏡。

最後，我謹祝出席今次會議的嘉賓事事順遂。我們能夠共聚一堂切磋研究，實在是一個極爲難得的好機會。

RECOMMENDATIONS OF FUTURE DIRECTION OF SERVICES FOR YOUNG HANDICAPPED CHILDREN IN HONG KONG

(1) Rationale for Early Intervention

1.1 It is increasingly evident that early intervention for handicapped and high-risk children is of crucial importance. Researches indicate that the earlier such children are identified and appropriate intervention programmes provided, the greater the chances that their handicaps be ameliorated and the quality of life of these children and their families be improved. It is thus evident that the effects of early intervention may extend well beyond the child's primary handicap.

1.2 The goal of early intervention, then, is to prevent or reduce the severity of a handicapping condition so that the child and his/her family are able to function adequately. Specialized early intervention programmes include home intervention and centre training. Most of these programmes advocate the involvement of parents as an integral partner in training because of their unique relationship with their children.

1.3 In the United States, Public Law 99-457 stipulated the development of a statewide, comprehensive and coordinated system to provide early intervention services for handicapped children and their families. There is at present no similar legislation in Hong Kong. It is time that the current policy on the care, education and training of young children with special needs should be reviewed so that legislative support for a more comprehensive system covering the families could be developed.

(2) Trends in Early Programming

2.1 Despite full awareness of the value of accurate individual diagnosis on service provision, there is a move toward noncategorical programming to meet the multiple needs of young handicapped children. Since early symptomatic conditions are not easily detected and classified into deficits and categories by labels, it appears essential to develop programmes designed to meet functional needs rather than to perpetuate discrete and separate categories for young children.

2.2 Integration of young handicapped children with their normal peers in a socially stimulating and responsive environment is important to enable them to establish productive and satisfying relationships in the early years. To achieve this aim, the number of places for handicapped children in a regular child care centre/kindergarten has to be increased substantially. In addition, supportive services for parents, teachers and children are imperative in providing a comprehensive and rehabilitative programme.

(3) Provision and Coordination of Services

3.1 Continuity in services from one stage to another is very important for handicapped children since this prevents them from unlearning what they have previously acquired. However, due

to the lack of available places in some types of services, children very often have to wait for months or even years before they are admitted to a suitable programme. This defeats the purpose of early identification and intervention.

3.2 As an interim measure, temporary services should be provided to fill the gap arising from the shortage of placement. Examples of such are:

a) child assessment clinic to provide some rudimentary training for parents and children waiting for pre-school service;
b) home-based training for those waitlisted for special school and
c) special training courses for graduated students who are waitlisted for adult service.

3.3 Continuity should be stressed in the transition of handicapped children from one type of service to another. In this respect, coordination among professionals/organizations /departments providing services to children at different ages and stages should be strengthened. Reassessments should take place periodically to plan for appropriate services in accordance with the child's changing needs.

3.4 Information and enquiry services should be set up to help parents locate and gain access to appropriate and needed services. A central directory of services and resources should be available for parents' reference.

(4) A Family-centred Approach to Early Intervention

4.1 Young children with special needs are uniquely dependent on their families, especially the parents, for survival and nurturance. This dependence necessitates a family-centred approach to early intervention. In other words, it means that intervention services should be provided to the handicapped child within the context of his/her family with recognition of the individuality of families. To this end, an Individualized Family Service Plan (IFSP), similar to that being practised in the United States, could be considered.

4.2 The family-centred approach implies the following service directions:

a) services provided should be tailor made to suit the specific strengths, needs and resources of each child and his/her family,
b) the autonomy, independence and decision-making capacity of the family should be promoted so that they can be actively involved in the choice of intervention services for their children and
c) collaboration and partnership between the family and professionals should be maintained at all levels, including the planning, delivery and evaluation of services.

To achieve the above, adequate manpower support, especially in the social work profession, is needed.

(5) Parents' Involvement

5.1 Professionals' knowledge and experience to work with handicapped children is well established. Yet successful rehabilitative services require parents' participation as well. Parents should be involved in every level of service as they have lengthy and intensive experience with their children.

5.2 Parental involvement does not mean the involvement of merely the mothers. Research has shown that a father often sets the tone for the family when coping with a child with special needs. Fathers should therefore be encouraged to play a more active role in all aspects of their children's lives.

5.3 Apart from continuing with the training programme at home, parents are encouraged to establish a warm, natural and reciprocal relationship with their children. Such kind of supportive parent — child relationship is effective in bringing forth long-term benefits on the overall development of the children.

5.4 Being the ultimate persons responsible for the future of their children, parents need to become more confident and competent in supporting the growth and development of their children. To enchance this, they should be helped to:

a) understand the results of the assessment and the abilities of their children;
b) know the various kinds of services available in the community and to select those which are suitable for their children;
c) acquire the necessary knowledge and skills in decision-making and handling their children;
d) enhance their confidence and realize that their role as prime educators should be and could be performed regardless of their level of education.

5.5 Peer support among parents is vital in overcoming the traumatic experience of having a handicapped child. Therefore, parents groups/organizations should be established to promote mutual support and to advocate for their children's right and services.

5.6 One of the ways to facilitate the foregoing parental involvement is to set up a parents resource centre which includes a wide range of services such as:

a) a resource library to provide information on handicap and disability in young children and on services available in the community;
b) enquiry, referral and counselling services;
c) mutual support groups to help parents share their experiences and feelings;
d) toy library for handicapped children and their caregivers;
e) recreational and educational functions for families.

(6) Preparation for Early Intervention Professionals

6.1 The term "early intervention professional" is used to mean any professional (including direct teaching personnel) who provides early intervention services to children and families. In line with the proposed family-centred approach, professionals should be trained to acquire new attitudes which recognize family competence and resourcefulness. To ensure genuine family/professional collaboration and partnership, professionals should shift their roles from instructors to enablers.

6.2 Communications between families and professionals can be difficult. Professionals should also possess non-intrusive, supportive skills to build up parental self-confidence and involvement. Interpersonal skills training should be included in training programmes to prepare professionals to work with other professionals and parents of handicapped children.

6.3 To facilitate collaboration among various disciplines, professionals should pool knowledge and skills together across disciplinary boundaries. As the multi-faceted problems of young children are too complex to be managed by a single discipline, different professionals of the same team should share the common task of assessing a child's developmental level and implementing a programme plan which meets the assessed needs within the context of the family. Conflicting directions to parents should be avoided.

6.4 To this end, the feasibility of selecting a case manager to provide continuity of services for families, to integrate the recommendations of various team members and to advocate on behalf of families could further be explored.

(7) Services for Autistic People

7.1 As autistic children constitute a heterogeneous group, the present diagnostic system should be further refined so that sub-categories with distinguished symptoms will be made possible. From a service point of view, heterogeneity in terms of intellectual level and level of language has important implications for service planning. A comprehensive multi-disciplinary assessment of the functioning of each autistic child and the families is therefore deemed necessary.

7.2 Autistic children should be placed in the appropriate service according to their individual needs. Considerable effort should be directed toward the integration of the clinical and educational elements of the programme so that an accurate assessment is followed by the provision of suitable teaching and services.

7.3 With heightened awareness but inadequate understanding of autism in Hong Kong, a Working Party, composed of different professionals from both the Government and the voluntary sector, should be set up:

a) to study the needs of autistic children and adults i.e. their medical, social, educational, vocational and residential needs;
b) to review existing services available to them in Hong Kong;
c) to plan for the provision of comprehensive services for autistic people with or without mental handicap;
d) to coordinate efforts of different disciplines and
e) to evaluate the effectiveness of intervention programmes and services.

(8) Curriculum Design

8.1 Individualized training programmes should be designed to suit the individual needs of each child.

8.2 The curriculum should be based on clear goals and objectives which focus on behaviours as well as processes. Programme planning should allow for a heuristic approach that calls for activities that build upon the children's own initiatives. Nevertheless, for autistic children who lack initiative, parents and professionals still have to input an appropriate degree of structure in their activities.

8.3 The developmental approach should continue to be adopted when designing curricula. In view of the paramount importance of the handicapped child's repetory of social skills in his attempts to integrate into society, however, the area of social competence needs greater emphasis than in the past.

(9) Research and Evaluation

9.1 So far there has been very little research done on the effectiveness of the early intervention programmes in Hong Kong. In order to upgrade the quality of services and to ensure the cost effectiveness of the funds spent on these programmes, such research should be widely encouraged.

9.2 Professionals should continue to create new horizons of services with an attitude of experimentation and creativity. After experimentation, programmes suitable to the child's needs could be adopted, while systematic evaluation of their effectiveness could furnish material for continuous modification and refinement.

(10) Conclusion

10.1 This symposium has brought in international and local expertise to affirm the value and needs of early identification and service provision for children with special needs. Valuable experiences and new ideas on assessment, treatment and training have been shared. It is hoped that such concerted effort can be sustained and exemplified to enhance the quality of life for these children and their families in Hong Kong.

Heep Hong Society for Handicapped Children

香港特殊幼兒服務未來發展的建議

(1)早期介入的理論基礎

1.1 對於弱智/弱能及有此表現的兒童而言，早期介入服務實在日益重要。兒童越早受到甄別，不但可以抑制其他併發症的發生，更可以提高改善學習困難及傷殘程度的機會。而他們的家庭所面對的壓力，亦可能相繼減輕。所以，早期介入影響的深遠，實在不單限於應付兒童的傷殘症狀。

1.2 早期介入的目的，就是要防止或減輕兒童的傷殘程度，使他/她和家庭都能充份地發揮其功能。鑑於家長與兒童的特別重要關係，特殊早期介入訓練課程一般包括中心和家居訓練。而其中大部份課程並有家長參與釐訂教學目標。

1.3 在美國，公眾法例第 99-457 條規劃了一個全國性、周詳而協調的體制為弱智/弱能兒童和他們的家庭提供早期介入服務。然而到目前為止，香港仍沒有類似的法例來照顧弱能/弱智兒童的需要，相信現在正是時候讓我們檢討一下目前有關護理、教育和訓練特殊兒童的政策，以便釐訂一個有法例支持而又完善詳備的服務體系來照顧他們及其家庭的需要。

(2)早期訓練的趨勢

2.1 誠然，準確的個別診斷在提供服務方面貢獻良多。不過為了配合弱智/弱能兒童多方面的需要，目前趨勢傾向以不分類形式教導兒童。由於早期症狀並不容易被甄別區分，所以釐訂適當訓練課程來配合兒童在不同功能上的需要，反而比過早把幼兒分門別類更加實用。

2.2 讓弱智/弱能兒童在一個充滿新鮮感及有回應的社交環境中與正常兒童溶合一起，肯定可幫助他們從幼便建立良好的人際關係。要達到這個目的，在混合幼兒中心/幼稚園裏弱智/弱能兒童的數目就必須有實質的增加。同時，對家長、老師和兒童的支援服務，亦是完善復康計劃的重要環節。

(3)服務的提供及協調

3.1 為避免兒童在輪候期間荒廢以往所學，不同階段間的服務銜接非常重要。然而由於服務不足，弱智/弱能兒童往往需要輪候數月、或甚數年，方有機會接受合適訓練。這實在和早期甄別和早期介入的原意背道而馳。

3.2 鑑於以上情況，設立暫時性的服務實有必要，用以幫助因學位不足而引致學習停滯的兒童。這些服務包括：

a) 智能中心為兒童及其家長在其等候學前服務期間提供起碼訓練；

b) 為在輪候中的兒童提供家居訓練；

c) 為已經畢業而仍在等候成人服務的人士安排特殊訓練課程。

3.3 即使服務在銜接的時間上沒有延誤，有關的專業人士／機構／部門也要緊密聯系，以促進兒童順利過渡到一個新階段的訓練。兒童最好能定期接受評估，以便按著他們的轉變來計劃合適的服務。

3.4 設立諮詢服務協助家長找尋切合需要的服務，亦有一定的價值。最好能編纂一份有關各項服務和資源的中央索引，以供家長參考。

(4)一個以家庭為重心的早期介入路向

4.1 有特殊需要的幼兒，往往全面依賴他們的家庭，尤其是父母的供養和培育。順應這依賴的特性，早期介入自然需要以家庭為中心。這意味著提供介入服務給弱智／弱能兒童時，需要考慮他們家庭環境及其個別獨特性。現正在美國推行的個別家庭服務計劃（IFSP）是一項值得參考的計劃。

4.2 一個以家庭為重心的路向，包括以下幾個方針：

a) 所提供的服務，應按著個別兒童和他／她的家庭的獨特專長、需要、資源而個別設計的。

b) 應鼓勵及提高每個家庭的自主、獨立和決斷能力，使他們能積極參與選擇提供予子女的介入服務。

c) 不論在計劃、推行和檢討服務或其他層面上，應鼓勵家庭和專業人士保持緊密合作，並肩努力。

要實踐上述方針，社工及其他專業人手的支援必須充裕。

(5)父母的參與

5.1 成功的復康服務不單仰賴知識及經驗豐富的專業人士，亦需要家長的積極參與。由於家長和子女長期接觸、體驗深刻，每一層面上的服務都需要他們投入協助。

5.2 除母親外，我們也應鼓勵父親在子女生活各方面中扮演一個積極的角色。許多研究均指出，在面對有特別需要的兒童時，父親的態度往往影響整個家庭的反應。

5.3 除了在家中訓練子女外，我們也鼓勵家長和子女建立一個溫暖、自然而又互相關懷的關係。而研究也證實一個良好的親子關係，對兒童的整體發展，有深遠的裨益。

5.4 子女的將來，究竟都是家長的責任。家長需要有信心和能力來鼓勵子女的成長和發展。要增加他們這方面的能力，我們便要幫助他們：

a) 了解評估的結果和自己子女的能力；

b) 了解社會現有的服務和替子女作適當的選擇；

c) 增進有關知識和技巧，以能替子女作出明智決定及教導他們；

d) 提高自信心和協助他們明白到不論他們的教育背景如何，他們都是教導其子女的主腦人物。

5.5 要克服因擁有一個弱能子女而帶來的痛苦經驗，家長需要彼此支持及幫助至為重要。因此，家長們應該組織自己的團體來互相支持，並為他們的子女爭取合理的權益和服務。

5.6 一個可以促進上述家長參與的方法，就是設立一個家長資源中心，提供以下各類型服務：

a) 參考圖書館以增加家長對其子女傷殘的了解，並提供社會有關方面服務的資料；

b) 詢問、轉介和輔導服務；

c) 互助支持小組讓家長們分享彼此經歷和感受；

d) 玩具圖書館和子女暫托服務；

e) 為家庭提供康樂及教育活動。

(6)早期介入專業人員的培訓

6.1 「早期介入專業人員」就是指那些為弱智兒童及其父母提供早期介入服務(包括直接教導工作)的人士。若要推廣「以家庭為重心」的早期介入,則在訓練專業人士時,必須灌輸一套推崇及尊重家庭的潛能和資源的態度。要確保家庭和專家之間存在真正的合作和夥伴精神,專家們就得把自己從教導者的角色轉移到教學啟導者上。

6.2 很多時候家庭和專業人士在溝通方面會遇上困難。因此專家們需要有容人之量、平易的態度,方可協助家長建立責任感。人際關係技巧也應被列入培訓課程,讓專業人員學習如何和同僚及家長相處。

6.3 為了促進不同專業間的合作,專業人士們應摒除界限,把自有的知識和技巧滙集在一起。由於幼兒的發展十分複雜,實非單一專門行業可以完善地處理。因此專業人士應該共同分擔評估兒童發展程度和推行切合個別家庭需要的訓練計劃。應盡量避免給予家長互相矛盾的建議。

6.4 有見及此,設立個案統籌員(Case Manager)的可能性值得繼續探討,以便提供有連貫性的家庭服務,綜合不同專業人士的建議和幫助家庭爭取權益。

(7)自閉症人士的服務

7.1 「自閉症兒童」這個概括的名稱實由不同類型的兒童組成。因此我們需要一個更精細的診斷系統,以區別顯著不同的症狀。在提供服務的立場來說,劃分智力和言語能力,對編訂服務有重大的意義。因此對每一個自閉症的兒童和他/她的家庭來說,一個完善而周詳的評估是必要的。

7.2 我們應該按照自閉症兒童的個別需要而提供適當的服務。臨床診斷和教育兩者之間的配合,仍有待改善,以方便兒童在準確的評估後繼續得到適當的教學服務。

7.3 目前本港對自閉症人士的問題日益關注,但有關這方面的知識依然貧乏,所以實在有需要邀請來自政府和私人機構的專業人士組織一個工作小組,以便:

a) 探討自閉症兒童和成年人的需要,其中包括醫療、社交、教育、職業及院舍服務等環節;
b) 檢討本港現有的服務;
c) 為兼有或純自閉症人士安排周詳的服務;
d) 統籌不同專業的貢獻;
e) 評估現有的訓練課程和服務的效用。

(8)課程設計

8.1 訓練課程應按著每一個兒童的個別需要來釐訂。

8.2 明確的目標固然重要,但課程也應依照兒童的自發能力採用啟導教學方法。對於自發性較少的自閉症兒童,家長或是工作人員仍需安排較緊湊有組織的活動。

8.3 在設計課程方面,兒童發展學說應該繼續被採用。至於經常被忽略的社交能力訓練,更需要特別重視,因為它在弱能兒童與社會的融合上,扮演一個十分重要的角色。

(9)研究和評價

9.1 到目前為止，在香港只有極少量研究提及有關早期介入服務的效用。為了提高服務質素和證明在這些訓練課程上的投資物有所值，我們應該鼓勵進行這一方面的研究。

9.2 專門人士應抱有實驗精神和創造勇氣，繼續探討一些不同的路向。透過實驗找出一些適合兒童需要的訓練課程，有系統地檢討它們的效用，以便作出修訂和改良。

(10)結語

10.1 是次專題研討會，邀請了國際及本港專業人士，去確認為有特殊需要的兒童，提供及早甄別及介入服務的重要性，並交流有關評估、治療及訓練的寶貴經驗及創見。謹希望各方面今次的努力，得以保持及發揚光大，以提高特殊兒童及其家庭的生活質素。

協康會

RECENT TRENDS IN EARLY INTERVENTION

Michael J. Guralnick

It is a very special pleasure today to have the opportunity to participate in this important symposium on "Working with Young Handicapped Children — The Way Ahead". The field of early intervention has certainly been central to my career as a researcher, as a provider of services, and as an advocate for services for young handicapped children and their families. In fact, three years ago, those of us involved in early intervention in the United States celebrated the passage of Public Law 99-457. This new law requires that, by the year 1991, services to all children with handicaps ages 3-5 years be provided in all 50 states in the United States. It also calls for the creation of a new program in each state for children from birth to 2 years of age with disabilities, as well as for those at-risk for developmental problems. Accordingly, we now have in place a public policy that through law both insists and encourages the development of a coordinated system of services for at-risk and handicapped children ages birth through five years. This is, in my view, a truly remarkable achievement, since such programs were virtually unknown two decades ago.

In my comments this afternoon, I would like to touch on a number of current as well as fundamental issues in the field of early intervention. First, I think it is worthwhile to consider, albeit briefly, why so much importance is attached to intervention during the early years. Having done that, I will then provide an overview of recent research designed to evaluate the effectiveness of early intervention. In this way, I hope to establish a framework for what might best be described as providing optimistic, yet realistic, expectations with regard to the impact of early intervention. Finally, a number of important issues, best practices, and unresolved problems will be discussed. Included in this discussion will be the role of families, the importance of developmental principles, continuity of care, social competence as it relates to the integration of handicapped and non-handicapped children, and training.

Rationale for Early Intervention

A reasonable question is to consider why so much emphasis should be placed on early intervention. What is the rationale for the generation of such enthusiasm for experientially-based interventions, not biomedical ones such as pharmacologic intervention or even neural transplantation approaches now receiving serious attention in many countries? How could such seemingly benign, straightforward, typically non-intrusive, environmentally-based therapies yield significant developmental effects with long-term consequences?

In fact, from an historical perspective, there were many powerful forces that led to today's interest in early intervention. Contributing factors included the strong environmentalism of the 1940s, giving rise to a behavioristic tradition and an emphasis on reinforcement procedures; the emergence of theories of personality development and ethology suggesting the long-term consequences of attachment and other early experiences; neural systems models arguing for the plasticity of the central nervous system during the early years; laboratory research on infants' abilities in the 1950s and 1960s demonstrating the existence of an active intellectual life for even very young children; and finally, research on children raised in depriving environments providing early empirical evidence that perhaps substantial changes in intellectual functioning could occur through environmental manipulation.

Although logical and empirical support for many of these developments as they related to early intervention can be seen as suspect in light of contemporary thinking and research, these factors nevertheless helped to focus the field's attention on the early years. However, perhaps the most persuasive argument from my perspective for the potential value of early intervention is the now compelling evidence suggesting that many at-risk and handicapped young children were and continue to find themselves in potentially non-optimal developmental environments. If this is the case, perhaps the course of development can be positively altered by appropriately adapting those environments.

Looking more closely at this issue and focusing on typically developing children for a moment, literally hundreds of experiments in the past 20 years have documented how parents adjust, in a rather exquisite fashion, the nature of their social, communicative, and cognitively-related interactions to their developing child's abilities and interests. These early adjustments, in particular, are tied closely to their child's developing competence and, as we now know, form the foundation for a child's cognitive, social, and communicative development. Concepts reflecting these parent-child relationships such as reciprocity, mutuality, and synchrony have now become indispensable to our understanding of early childhood development.

However, in recent years, when investigators assessed the caregiving behaviors of parents of at-risk or handicapped young children, a number of problems became apparent. These problems could perhaps best be characterized by the term mismatch, as children and parents often failed to achieve the reciprocity, mutuality, and synchrony generally found in relationships with typically developing children.

Upon reflection, these results should have been anticipated as parents of handicapped children, in particular, enter into very uncertain relationships with their child. For example, the signalling capacities of many handicapped children are reduced; their eye contact and other social regulatory mechanisms are often disorganized; and an imbalance exists across children's developmental domains. Moreover, young handicapped children have difficulty in modulating arousal causing strains in parent-child relationships; and often found autonomic nervous system dysfunctions mitigate against satisfying emotional relationships, as even such basic attachment mechanisms as children's social smiling is impaired. From the perspective of families, they are likely undergoing considerable stress, certainly surrounding the diagnostic process. Unfortunately, this stressful process is repeated over the early years as various transition points during early childhood highlight the scope and nature of the problems to be faced. Finally, this turmoil is often exacerbated by the general uncertainties parents experience as to what is expected of them.

In view of these patterns of stressful and probably non-optimal developmental environments, the practice of early intervention is presented with a clear direction. Specifically, although translation of an understanding of problems associated with non-optimal environments to intervention has only occurred quite recently, there is reason to believe that if parent-child interactions can be matched more closely to the developmental characteristics of their child, providing the responsive stimulating environment that characterizes relationships for most typical children, substantially improved development should follow. In fact, it may be suggested that without intervention under these circumstances, we are likely to see a gradual decline in developmental functioning over time as a consequence of the compounding effects of early and continuing mismatches.

Evaluation of Effectiveness

As I mentioned earlier, the movement towards early intervention has culminated in the United States with the recent passage of Public Law 99-457. In many respects, this law stands as a public policy statement exhibiting confidence that early intervention services will indeed yield substantial benefits for children and families.

However, it is fair and appropriate to question whether this confidence is justified. What evidence is there that early intervention for at-risk and handicapped children actually works? If there are benefits, what is their scope and magnitude? Of course, the seemingly logical and straightforward nature of these questions obscures the enormous diversity found in the field of early intervention. The populations of handicapped children vary markedly, traditionally grouped as children with motor problems (primarily those with cerebral palsy), language and communication disorders, mental retardation, sensory handicaps, and emotional disorders. Even within these categories, the variability in terms of severity of the disability and associated disorders is astounding. When you combine this with the equally complex array of different early intervention programs varying in terms of when intervention begins, its intensity, length of treatment, and type of developmental/educational model, one can clearly see why evaluation is so complex.

In response to this diversity, an important strategy to evaluate effectiveness that has been taken has been a statistical one, referred to as meta-analysis. In this approach, all available research, published and unpublished that meet certain criteria related to the evaluation of effectiveness are grouped in an effort to detect any global statistical trends. Certain assumptions are made that may be questionable, but this is actually a powerful statistical methodology. In essence, outcomes from diverse studies of children are transformed to yield an effect size measured in standard deviation units to allow comparisons across studies.

When this procedure is applied to virtually all of the early intervention studies that have been carried out meeting minimal inclusion criteria, one does, in fact, find an overall positive impact of early intervention. That is, the mean effect size for intervention groups exceeds the mean effect size for control groups shortly after intervention by approximately one-half of a standard deviation. Since most outcome measures were based on intelligence test scores, this translates into a benefit to those participating in early intervention of perhaps 8 I.Q. points.

This difference of 8 I.Q. points has been confirmed in a separate analysis of the literature I carried out for children with Down syndrome. As you know, without intervention, there is a decline in measured intellectual development for children with Down syndrome that begins around the first year of life and continues throughout the preschool years. The magnitude of the decline is approximately 8-12 I.Q. points. However, when children with Down syndrome are enrolled in early intervention programs, we now have consistent evidence that this decline in intellectual functioning can be prevented to a substantial degree when comprehensive programs are implemented immediately. Longitudinal studies from Australia, Israel, and the United States have confirmed this important effect of early intervention.

Consequently, despite the complexity of programs and populations, there exists evidence that has converged from various evaluation strategies that, indeed, early intervention approaches are effective. Specifically, it can be stated that the usual declines in intellectual development can be prevented. Moreover, we know that improvements will occur, perhaps not to the same extent, if intervention is begun at a later point. Recent analyses have suggested that, for mildly impaired children at least, superior developmental outcomes do occur when intervention is begun before 6 months of age, although there is considerable value to efforts initiated after that time as well.

Admittedly, the expectations of the effects of early intervention for parents, policy makers, and early childhood professionals were probably far greater than what has been revealed in existing studies. The enthusiasm that has characterized the field of early intervention carried with it, if not an expectation of "cure", at least an anticipation that a more substantial impact would result than that which appears to be typically obtained.

But is this the best we can do? I think not for a number of reasons. First, on close analysis, these results can be viewed as constituting only the minimal effects we can expect of early intervention. I say this with confidence because the results I just reviewed were based on what might best be referred to as a first

generation of early intervention programs. It is only within the last 15-20 years that these programs have begun; it takes many years to develop and refine curricula, to train staff appropriately, to integrate the many disciplines needed to promote services to handicapped children, and to create an efficient and supportive administrative structure to support and generate needed services for these programs. Accordingly, in view of the fact that effectiveness research was based on early intervention programs that were themselves grappling with many problems suggests that perhaps better outcomes will occur with a more sophisticated second generation of early intervention programs. In a few moments, I will provide a sense of what I consider to be the best practices of these second generation programs.

A second reason why the initially modest results should not be considered too disappointing is the fact that most outcome measures were focused virtually exclusively on children's cognitive development. Let me suggest that, although this is clearly a factor of major importance and it is understandable why researchers and program developers utilized this measure so frequently, the narrowness of an exclusively cognitively-oriented approach may have underestimated the impact of family functioning or children's social competence may prove to be more valuable and significant throughout the course of the life cycle.

Second Generation Programs and Best Practices

Focusing now on what constitutes best practices of second generation programs, a number of important characteristics can be identified that differ substantially from earlier thinking. First, the role of families in the early intervention process has changed as have our perceptions of parent-professional relationships. Second, early intervention curricula are taking a decidedly more developmental focus with a corresponding shift away from highly structured behavioral objectives. Third, curricula that consider social competence as a basis for integrating the different developmental domains are becoming more prominent. Fourth, there is now a greater understanding of the need for an emphasis upon continuity of care. Finally, the context and nature of the training programs for those providing direct services to at-risk and handicapped children and their families has evolved to be compatible with these general trends in early intervention programs. Let me address each of these issues separately.

(1) ***Families***

For the majority of first generation early intervention programs, parents served primarily educational or instructional functions. In some programs, following training by professionals, parents even became primary service providers themselves. In other circumstances, parents functioned to support and extend educational activities in the home for children enrolled primarily in center-based activities. Of course, parents have also benefitted from the counseling and support provided by programs. Early intervention programs helped to organize parent groups, and often specialists were brought in to discuss various topics of interest.

In the last few years, the field of early intervention has shifted quite substantially from asking parents to serve in a predominantly teaching or didactic role. Two issues prompted this restructuring. One concern was that the teaching function fostered a sense of dependency on the part of parents, as they often mechanically carried out specific exercises and activities of which they had only rudimentary knowledge. In essence, parents became apprenticed to the "experts", but could never achieve expert status. A second concern was that specific teaching functions can, in many instances, interfere with the development of appropriate parent-child relationships. In essence, it is argued that highly structured, sometimes repetitive teaching activities can come to dominate a relationship, detracting from the more natural forces that bind parents and children together. It is further suggested that since these fundamental relationships are essential for providing an optimal

developmental environment over time, it is precisely the fostering of natural, supportive, and reciprocal relationships between parents and children that should be the focus of the professionals' activities.

Accordingly, we see that two forces, each complementing one another, have emerged in a manner which has produced a revision in our approach to families for the second generation of early intervention programs. One force suggests a more equitable parent-professional relationship is in order. Parents need to remain in control and become more confident and competent in supporting the growth and development of their child. The fundamental decision-making ability must remain within the family unit whenever possible. There are now many models of community-based care in the United States, including those involving highly specialized tertiary care centers which represent this approach. Technical knowledge of the specialists can help build that confidence and competence of parents as well as provide appropriate counsel in issues vital to the family.

The second force suggests that a new "relationship-focused" rather than an "instructional-focused" approach is in order. The building of warm, responsive, reciprocal, and synchronous relationships between parents and children is seen as taking precedence over any other functions. Perhaps through these efforts, long-term benefits may be forthcoming.

Is there any empirical evidence that second generation early intervention programs adopting this approach to families are effective? In fact, recent studies do suggest the value of this approach for children at risk as well as for those with developmental handicaps. Specifically, prematurity is a major risk factor for developmental delay in the United States with nearly 200,000 premature/low birthweight babies being born each year. The question is, can "preventive intervention" strategies minimize or perhaps prevent entirely the developmental problems that are associated with this risk factor? A recent and carefully controlled study with this population perhaps reflected the best features of second generation research. Premature/low birthweight children without frank neurologic handicaps were assigned randomly in a prospective longitudinal study to intervention and conventional care groups. A matched full-term group of infants was also included. The intervention strategy was consistent with the family-centered model I have been discussing and was administered prior to the child's discharge from a neonatal intensive care unit and extended an additional three months. The key to the intervention program was to improve the ability of the mother to recognize and support her own infant's abilities. Establishing caretaking routines, building synchrony and reciprocity, and generally improving the competence of mothers were essential goals of the program.

The results of this excellent study were actually quite remarkable. For children in the control group (conventional care), a gradual but persistent decline in intellectual functioning was observed over a four-year period; a pattern that I have mentioned is quite typical of many groups of at-risk and handicapped children. In contrast, the average I.Q. of the intervention group gradually increased over the four years, stabilizing at the level of the healthy full-term group. By four years of age, nearly 13 points on the McCarthy Scales of Children's Abilities separated the treatment and control groups. For children at-risk, this is a very substantial and clinically significant difference, especially in view of the low cost and intensity of the intervention.

How is it possible for a straightforward, inexpensive, highly time-limited treatment to create such a substantial and sustained effect on children's cognitive development? The answer seems to reside in the ability of the intervention program to promote sensitive transactions between parent and child that continued to evolve naturally as growth and development proceeded over the course of the four year period. In fact at six months, direct measures of maternal self confidence with respect to competent parenting and satisfaction with the mothering role revealed that intervention group mothers perceived themselves as more self-confident and were more satisfied with their role

than control group mothers. In addition, control group mothers perceived their children to be more difficult than intervention group mothers.

It may well be that this initial positive orientation and confidence brought about by the intervention program, in conjunction with training on special concerns associated with premature/low birthweight infants, were sufficient to build a parent-child relationship that was not only a developmentally supportive one but also was able to be sustained over many years. As suggested by declines in the control group scores, the absence of these parenting skills and attitudes apparently leads to conditions that fail to provide the type of environment needed to promote typical developmental growth.

Does this family-focused approach make sense for children with documented disabilities? Preliminary evidence from a study of children with cerebral palsy is encouraging. As you know, cerebral palsy is a major developmental disability often occurring in combination with other handicaps. One of its most prevalent forms is spastic diplegia, a disorder commonly associated with prematurity. Recent research comparing neurodevelopmental therapy with a comprehensive primarily parent-oriented infant stimulation approach for 12-19 month old children with diagnosed spastic diplegia revealed some interesting findings. Focusing on motor development as assessed by the Bayley Scales, the highly limited physical therapy only approach was not effective over a one year period. In fact, the ubiquitous decline in developmental rate was observed. In contrast, motor development for the group receiving general infant stimulation revealed a gradual increase. At the end of the year, e.g. a 15.4 point difference existed between the two groups. Again, a rather substantial difference.

Why did this occur? Why should a comprehensive infant stimulation program have produced this difference in motor development in comparison to a well designed and implemented protocol of neurodevelopmental therapy? The authors of this research study speculate that: "The positive effects of infant stimulation in the trial may be due to better or broader understanding by the parents of the infants' development and capacities, which may have improved their ability to cope and interact with their infants." Clearly, this analysis is consistent with the work on children at biologic risk noted earlier.

Assuming that a family-centered approach continues to receive support, we must begin to better understand the processes associated with these parent-professional relationships. Models of development and a philosophy for program implementation provide essential frameworks within which our interactions can be organized. However, our field is characterized by large-scale individual differences, and a generalized application of any approach is likely to be a disservice to many families. In its wisdom, the centerpiece of Public Law 99-457 is its family-focused nature, but it requires a highly individualized approach as well.

(2) *Curriculum Development*

Paralleling these changes in the role of families are changes in the orientation of curricula for children with handicaps. There is now a perceptible retrenchment from curricula that are highly structured and domain specific. To be sure, structure matters; program organization matters. In fact, if there is one consistent finding regarding the effectiveness of early intervention programs, it is that clear goals, structure, and the organization of programs are associated with better outcomes. Yet, the trend is to retain a structure and organization provided by a curriculum but to make it more subtle, i.e. less directive. Individual child goals and objectives are important but curricula are becoming more heuristic, calling for activities that build upon children's initiatives and that reinforce

more natural interactions. In a real sense, the early intervention models gaining ascendance constitute a return to more fundamental approaches found in the general field of early childhood. The intent is to strengthen the natural learning processes of children and to continually find a means to intertwine their behaviors with those of others in the environment. It is scaffolding at its best. Task analyses may well be important, but so is the ability of parents, teachers, and child care workers to become more sensitive to children's cues and to utilize that information to help the child construct relationships and gain knowledge about the world. Similarly, new curricula tend to emphasize turn-taking and interactive matches designed to bring both parent and teacher behavior in closer correspondence with the handicapped child's behavioral style, complexity, developmental level, and interests. Please note that curricula based on these principles differ sharply from the highly directive curriculum approaches commonly applied to young handicapped children.

(3) *Social Competence and Integration*

This curricular approach also tends to focus on the integrative nature of children's interactions with the world; i.e. children's cognitive and social competence. Both of these competence domains require the integration of skills and abilities from language, motor, cognitive, and socio-emotional areas to assist the child to solve a cognitive or social problem. It is now becoming clear that first generation curricula did not attend sufficiently to the integrative nature of development.

Let me provide you with an example of why this emphasis on the integration of developmental domains in the interest of competence is so important. In recent years, one aspect of my own work has been devoted toward understanding the social competence of preschool age handicapped children. More specifically, I have focused on one important aspect of that social competence, i.e., peer-related social competence. As you know, the study of child-child social relations has received almost unprecedented attention in recent years. There is now unequivocal evidence that failure to establish productive and satisfying relationships with peers in the early years signals potentially significant difficulties in interpersonal adjustment in later life. Moreover, many researchers and theorists have suggested that peer relations and friendship in early childhood foster the socialization of aggressive tendencies, promote language and communication, and facilitate the development of prosocial behaviors and social-cognitive processes. Any indications that young handicapped children manifest unusual problems in this domain would suggest that their opportunities for productive and meaningful lives would be severely compromised.

Unfortunately, my research and that of others has revealed that, indeed, young handicapped children representing a variety of disabilities manifest deficits in peer relations that far exceed those which might be expected on the basis of their general developmental levels. In a series of cross-sectional and short-term longitudinal studies with developmentally delayed children in particular, a number of major deficits have been observed. Time will not permit a description of the details of these deficits, but let me outline some of the more significant concerns. Overall, handicapped children engage in a limited amount of group play, the most sophisticated and highest level of play evaluated on conventional assessment instruments. In fact, a substantial proportion of the children, as much as one-third, engage in virtually no group play whatsoever, and only relatively minor changes in this pattern occur over the preschool period (4-6 years of age). Even when handicapped children do establish friendships, they have great difficulty making use of the "developmental advantages" typically found in friendship pairs, including the occurrence of more complex and sophisticated play within that friendship dyad.

More detailed analyses of the child-child play of handicapped children revealed a general deficit in directing and organizing play, showing proper affect, and using others as resources as

needed. Important processes associated with negotiation and compromise in an effort to resolve conflicts as they arise during the normal course of play were not well established for children with disabilities. In general, emotional regulation processes were not strong enough to modulate the usual escalation and de-escalation of events that accompany child-child play. Moreover, deficits in processing information tended to make social cue recognition difficult to accomplish for handicapped children, further compounding problems in peer-related social competence. An important point to note here is that the deficit in social competence with peers is not readily predictable by scores on cognitive, language, or motor development tests. This is an integrative developmental process that requires a special form of early intervention.

Given these circumstances, what can be accomplished to reduce the deficits in peer relationships? One rather simple approach is to provide as socially stimulating and responsive an environment as possible. Research in the United States has established that for mildly and moderately handicapped children, the early childhood environment which enhances the quality and quantity of peer relations most effectively is one which includes nonhandicapped children, i.e., an integrated or mainstreamed one. In general, the frequency of important components of play is substantially more apparent in mainstreamed settings than in settings containing only other handicapped children, and the cognitive quality of children's play is improved as well. In fact, in a recent comparative study, I found that children in mainstreamed programs have more than twice the number of positive social interactions than those in specialized programs. Moreover, those peer-related social behaviors that did emerge were those that are very important to socially competent functioning such as directing others in play.

Participation of handicapped children in integrated settings, however, is only a partial solution to the peer interaction deficits that have been observed. I would argue that any significant and meaningful improvement in peer social competence is going to require the same level of inquiry as any other developmental domain. By that I mean we must develop an assessment procedure and developmental profile that allow us to understand the likely nature of this deficit. For example, is it related to minor behavior problems? Are we dealing with anxiety, passive behavior, or aggressive interactions? Are children's initial and follow-up entry strategies too intrusive? Are sequences of behavior in conflict episodes allowed to escalate?

The child's temperament or behavioral style should also be considered as a possible contributor to this deficit. Moreover, an analysis of cognitive functioning is in order as well, since difficulties can arise in many of the basic steps in social information processing. In my view, we must analyze a profile generated by such a comprehensive assessment to gain a clear direction for designing intervention strategies.

(4) ***Comprehensive and Continuous Care***

Of course, specific curricula or developmental models constitute important components of the larger system of early intervention services. In the United States, Public Law 99-457 requires that each state ensure implementation of 14 key elements of such a system. These elements include: (1) a comprehensive child find and referral system; (2) a public awareness program to focus on early identification; (3) a comprehensive multidisciplinary evaluation of the needs of children and families; (4) a central directory of services, resources, state experts, research and demonstration projects; and (5) an individualized family service plan which includes case management services.

The two themes that, in my view, are central to this system of early intervention are first, the provision of comprehensive services and second, continuity of care. The need for comprehensive and

continuous services is, to most of us in the field, a generally accepted fact, so I will not dwell on this issue. Clearly, handicapped children require services from numerous disciplines, including occupational and physical therapy, social work, early childhood/special education, speech pathology, psychology, nursing, and pediatrics, to name those most frequently involved. Included within this framework are assessments of family strengths and needs as well as broader environmental factors that might influence a child's development as found in the home and neighborhood.

Moreover, the fragile nature of many developmental processes suggest the significance of continuous care. Children are most vulnerable during transition points in their lives, such as from the hospital to home, and unless continuity is maintained we risk major setbacks. In the United States, considerable emphasis has been placed on the concept of a Case Manager to coordinate comprehensive and continuous care. These individuals can represent any discipline but have special skills designing management plans in the context of professional teams, accessing community services, encouraging networking among families, advocating for families, and ensuring the efficient and effective use of health care.

(5) ***Training***

The final topic I wish to discuss is the area of training. I recognize that this is an important issue in Hong Kong, but it is actually a worldwide concern. Over 20 years ago, a system of interdisciplinary training and service programs for handicapped children was established in the United States in which centers were created as part of major universities. The intent was not only to bring faculty together from many disciplines who were interested in handicapped individuals, but also to provide a center to attract students who would receive training in preparation for professional service. A great deal has been accomplished over these 20 years but the recent emphasis on training professionals in early intervention has stressed the system. It is not only the number of trained professionals for the many disciplines that are needed, but it is also the nature of the skills required of these individuals that have become a challenge. Consider for a moment the implications for training within a comprehensive family-focused approach, as well as one in which cognitive and social competence are essential components. Each of these areas requires a different set of knowledge, attitudes, and skills of those being trained. For those providing case manager functions, the training is especially demanding.

That fact that early intervention programs serving handicapped children and their families is multidisciplinary is both a strength and a liability. Problems arise when we attempt to construct a coherent training system, since each individual discipline has its own unique administration, certification, and university-based characteristics. As an example, over the course of the last 10 years, I directed a project to train pediatricians during their pediatric residency years to enable them to provide effective and sensitive services to handicapped children and their families by the time they enter practice. The need for a systematic, national effort in this area was apparent as relatively few hospital-based programs provided organized training experiences in the field of disabilities for pediatric residents, despite evidence that pediatric practice patterns were changing in a manner that produced greater involvement of practicing pediatricians with handicapped children. Time does not permit me to describe the details of this extensive effort, but I wish only to note that we followed a well travelled process in trying to establish a national training program. First, we obtained agreement as to core competencies drawing upon a National Task Force and other experts. Second, a curriculum was developed describing more specific objectives and establishing a range of flexible activities from clinical work to readings. Evaluation procedures were also built into the process. Perhaps most importantly, however, was the development of training guides and materials to help directors of training carry out the program. This included case studies, assessment materials, and

even videotapes for certain low incidence handicapping conditions. Finally, we worked continuously with key administrators at every level to try to anticipate and resolve the many political issues that inevitably arise.

Unfortunately, for most training systems, similar processes may well be needed for each discipline. For teachers and child care workers in particular, there exists a strong movement in the United States to establish separate training programs for those serving infants and toddlers (to 3 years of age) and those serving the 3-5 year old group. Different roles and, consequently, different competencies are being developed. The training process, particularly for infant-toddler specialists, is a long-term challenge. It will take some time to evaluate whether sufficient numbers of students can be attracted to this specialty area. For the 3-5 year old group, it is not possible to train large numbers of specialists. Accordingly, inservice training on topics related to handicapped children for general early childhood personnel has been emphasized. In many respects, this approach is compatible with the developmental focus described earlier. Special techniques regarding how to adapt structural and curricular features of the classroom for handicapped children and how to recognize the need for assistance for specialized services from the various disciplines and incorporate that information into practice is emphasized.

Summary

Those of us who are involved in providing services to young handicapped children and their families are engaged in an important and demanding enterprise. Its importance resides in the increasingly compelling evidence suggesting that the developmental pathways and trajectories established in the early years become increasingly difficult to deflect over time. We have also seen that through intervention in the first few years, we are capable of preventing declines in development that tend to occur in the absence of systematic intervention programs for children and families.

We have also seen that the framework and content of early intervention programs continue to evolve. New perspectives on parent-professional relationships and curriculum modifications reflecting a strong developmental approach as well as an emphasis on cognitive and social competence are altering important aspects of our approaches to early intervention. As the elements of comprehensive systems of care are brought together and evaluated and corresponding training programs developed, we can look forward to even more effective services in the years ahead.

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早期介入之最新趨勢

Michael J. Guralnick

今天我很高興能有機會參加這個名爲「邁向九十年代的特殊幼兒服務」的專題研討會。對於我這個既是從事弱智／弱能兒童方面研究工作，亦是推行和提倡有關服務的學者來說，「早期介入」這概念實在十分重要。三年前，美國通過了第 99-457 號法例。規定全國五十州須在 1991 年以前爲各自境內 3 至 5 歲弱智／弱能兒童提供適當的服務。同時亦要求各州爲 0 至 2 歲的傷殘或有傷殘傾向的兒童推出新的訓練計劃。因此，我們有了新的公共政策：法律保障 0-5 歲的弱能／弱智兒童有州政府爲他們提供有系統的服務。而這，我認爲是一項極重要的成就。二十年前，我們還未有這樣的意識和服務。

我今天的演講將會討論一些和「早期介入」有關的問題。首先我會簡單闡釋一下「早期介入」這方法的重要性，然後會概括介紹有關這方面的效用評估的最新研究。希望藉此建立一個架構，使人對「早期介入」的影響抱有一個樂觀但合乎實際的期望。最後我會討論一些與此息息相關的問題，包括了家庭扮演的角色、發展理論的重要性、弱能／弱智兒童照顧的延續性以及社交能力的培養和工作人員的培訓等。

早期介入的理論基礎

治療弱能／弱智兒童的方法很多，相等於藥物治療、神經移植等其他方法，爲什麼「早期介入」會受到如此重視？從歷史角度來看，引起我們注意「早期介入」這方法的因素實在不少。其中包括了四十年代的環境論、著重强化程序的行爲學說、以及人格發展理論認爲一個人早期對母親的依附(attachment)及生活經歷對他將來的性格有很深遠的影響等。與此同時，神經學模式的學者則提出幼兒時期中央神經系統(Central Nervous System)的可塑性(plasticity)。而五十和六十年代的多項實驗也証明了幼童同樣擁有活躍的智力生活。最後，我們又可以看到不少研究結果証明了改變一個人的環境是可以改變其智力發展的。雖然，經過更多的研究與實驗，以上的理論或多或少都會受到一些質疑，但至少他們却使我們將研究方向集中於幼兒階段。我認爲鼓吹「早期介入」的方法最重要的價值在於它可以改變一個大家都知道的事實——很多弱能／弱智兒童都是在一個無法盡其所能發展的環境(non-optimal developmental environments)下成長。假如我們將這些兒童的成長環境加以改善的話，他們各方面的發展是可以提高的。

在過去二十年中，數以百計的實驗都証明了父母如何按著成長中的子女的能力和興趣，在社交、溝通和智育方面作出了種種的適應。而這些早期的適應也成爲兒童日後智力、言語和社交能力發展的基礎。在幼兒的成長過程中，他們與父母的關係，(例如能否互相補足，互惠互涉等)是非常重要的。根據近年有關弱能或有弱能傾向的幼兒研究顯示，他們與父母之間的不協調似乎是一個大問題，他們之間無法達至互惠、互涉、互相補足、以及和諧的關係。

想深一層，這些問題的出現其實是最自然不過的了。舉例來說：不少弱能兒童無法好好表達自己，視覺以及其他方面的社交接觸都受擾亂，也可能是各方面發展未能平衡，也許是由於神經線未能控制自如而無法給予週遭的人一個天真可愛的微笑。對這些兒童的家庭成員來說，他們所遭受的打擊、遇到的困難是顯而易見的。不幸的是，這些困難並不會隨著弱能兒童的成長而減少。而他們的父母所感受的壓力、困擾也因這種無所適從和無法了解自己弱能子女的感覺而加深。他們所肩負的擔子實在很重。

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正因如此，我們相信「早期介入」是一個正確的方向——如果父母與弱能子女的關係能日趨「配對」，如果他們之間能有更多的溝通與了解，更相似父母與其他正常子女的關係，從而爲這些弱能兒童提供到一個配合他們成長特質的長大環境時，就肯定會對這些兒童的發展有莫大裨益。反過來說：沒有早期介入，弱能兒童由於不能與父母達至一個配對的關係，雙方無法溝通了解，他們的成長會受到影響，停滯不前，甚或出現倒退的現象。

「早期介入」的效用評估

上文提及的美國政府立法(法例第 99-457 號)規定各州必須爲州內弱能／有弱能傾向兒童提供早期訓練，實在是推行「早期介入」運動的高潮，也表示大家對「早期介入」這方法的信心。

爲甚麼會有這樣的信心？有甚麼事實足以証明「早期介入」實在對弱能／有弱能傾向的兒童有所幫助？這信心必須植基於對這方法的效用評估的結果。不過評估「早期介入」方法的效用，自然不是一件容易事，因爲它所牽涉的範圍與定義都是非常廣泛的。首先傷殘兒童的定義包括了因大腦麻痺而引致弱能的兒童，言語、感覺、情緒有困難的兒童，弱智的兒童等，而在這些症狀底下，還有程度上的差距。另一方面，早期介入訓練課程也有因强度、模式、長短等不同而有所分別，這些因素都使評估變得複雜。

有見及此，一項統計學採用的方法 Meta-analysis 可以用來作評估之用。根據這個方法，所有達到一定標準的效用評估和研究結果都會被歸納，以作探索全球趨勢之用。

當所有合乎標準的研究結果累積下來，我們便發現到「早期介入」對兒童確有相當的幫助。接受介入服務的兒童比沒有接受服務的兒童在智力測驗中高出了大概八個智商點。我也曾對患唐氏綜合症的兒童進行過一項跟進研究，發現了如果沒有介入服務，他們的智力發展就會在第一年開始退化，幅度大概是八至十二智商點。另一方面，早期介入，特別是半歲以前的介入却可預防這羣兒童智力上的衰退。

無可否認，家長、決策者和從事幼兒服務專業人士對早期介入服務的期望，往往都比目前調查所得的爲高。我也認爲目前資料所顯示的效果是偏低的，原因有二：一是因爲這些研究都是以第一代的「早期介入」服務爲對象。「早期介入」服務還是近十五、二十年間才正式開始的，而改良課程、訓練人手、融合各學科以求服務精益求精、建立一個有效的行政架構來支援服務的發展等工作，都需要一段長的時間方可做到。因此第二代的早期介入模式相信會帶來更大的成果。其次便是很多研究都採用兒童的智力發展來評估早期介入的效用，因而低估了後者的影響力。其實早期介入對家長的功能和兒童社交能力的影響，往往比智力發展更有價值，對兒童一生的影響更爲深遠。

第二代的「早期介入」服務

如果我們集中看看目前「早期介入」服務的優點，我們可以發現一些特色，而這些特色背後往往標誌著一些嶄新的觀念。首先，家庭在「早期介入」服務中所扮演的角色改變了，父母與工作人員的關係也有所改變。

第二：「早期介入」的課程漸以發展爲重心，而減少對行爲改變的要求。

第三：課程以社交能力爲基礎，統合其他各個發展範疇。

第四：大家更了解到延續服務的重要性。

第五：對工作人員的訓練也受這些新概念影響。讓我嘗試較詳細去討論上述幾個特色：

(一) 家庭

過往的早期介入訓練中，父母擔當著一個教導者的角色，透過專業人士的訓練，家長往往在家庭內進行教學活動；而透過家長會，家長們也可互相支持幫助。在最近數年內，家長的角色有相當大的轉變。其一的原因是以往家長機械式的執行一些他們不大熟稔的訓練工作，增加了他們對專家的依賴性。其二是過份著重訓練，會影響了父母和子女之間的關係。而這些出於自然而互相支持的關係，對提供

一個理想的發展環境極爲重要。如果因爲傳授一些特定知識而影響父母與子女的和諧關係，繼而傷害到兒童的長遠發展，那就太不值得了。

由此我們可以看到兩種相輔相承的力量出現了。其一是一種比較平等的家長－專家關係(Parent-professional relationship)的產生。家長需要更有信心和能力去幫助他們子女的成長。專家在這方面既可以提高科技上的知識以加强家長的信心和能力，也可提供家庭輔導服務。其二是以關係爲中心(relationship-focused)的取向替代了以教學爲中心(instructional-focused)的取向。家長和子女的關係，比傳授知識更爲重要。

(二) 課程發展

爲弱能兒童設計的課程也與這家庭的新角色相配合。傳統的課程較少靈活性，以特定認知／感性範疇爲本位(domain specific)。當然嚴謹之課程組織與架構有它一定的地位，但現在的趨向是要將課程塑造得較爲啟發式，而非直示式。目的是在於鼓勵兒童自然學習，並使他們的行爲與四週的人息息相關。事項分析(task analysis)雖然重要，但父母、老師和幼兒工作員亦要察覺到兒童的種種提示(cues)，從而幫助他們建立關係和認識這世界。同樣地，新的課程偏重把父母及教師與孩子的行爲模式、發展程度和興趣互相配合。

(三) 社交能力的發展與社會融合

如果兒童在幼年時期不能和其他兒童建立了一個良好的人際關係時，他們長大後和他人相處也會出現困難。而兒童在早期建立的友誼質素，也會影響他們在言語、社交、和智力方面的發展。可是一連串的研究却顯示出，弱智／弱能兒童只用了一少部份時間進行集體遊戲。其中有三份一的兒童幾乎是完全沒有任何參予。而這些情況在兒童接受學前教育階段只有些微的改善。就算弱智／弱能兒童能夠和其他兒童建立友誼，他們也很難參與一些較爲複雜的遊戲。而在遊戲中也缺乏表現領導、組織能力和適當情緒的機會。至於遊戲中解決問題常用的妥協方法，也是這些兒童所不懂應用的。大致來說，這些兒童在情緒失却自主控制情況下，社交技能往往受到影響。社交能力不足是智能、言語或機能測驗量度不到的。

那麼我們可以做些甚麼來培養他們的社交能力呢？答案就是提供一個環境讓他們有適量的刺激和有機會作出回應。很多研究都同時發現對輕度和中度弱智的兒童來說，透過與正常兒童的交往，最能提高朋輩關係的質量和數量。普遍來說，遊戲中所包含的原素，在混合環境(integrated setting)中比在特殊環境(special setting)中更爲明顯。最近的一項研究發現，接受主流教學方法(mainstreamed programs)的兒童和他人相處的時間比接受特殊課程的爲多。而他們在朋輩關係中所學習到的行爲對他們的社交發展十分重要。

除此以外，我們也需要設計一套測驗發展程度的有效指標，嘗試明白多一點這些能力不足(deficit)的性質。兒童的性情和行爲模式也可能是導致能力不足的成因。所以我們需要一個完備的評估方法使我們在設計介入服務時有一個明確的路向。

(四) 全面性和持續的照顧

在美國，法例 99-457 號要求每州推行「早期介入」服務時須留意十四要點，這些要點包括了：

1) 推行全面性的確認及推介服務，以求及早發現弱能或有弱能傾向的幼兒；
2) 喚醒大衆對早期甄別的關注；
3) 發展全面性及科際的評估，衡量弱能兒童及其家庭的需要；
4) 編纂中央引索，詳列各項有關服務、資源、專家、研究及計劃等資料；
5) 提供一個爲個別設計的家庭服務計劃，包括了個案處理服務。

這樣的一個「早期介入」計劃有兩重點：一是提供全面性的服務，二是提供持續性的照顧。這兩點大概已普遍爲人所接納，故在此不贅。很明顯，弱智／弱能兒童需要不同部門所提供的服務，例如物理治療、職業治療、社會工作、幼兒／特殊教育、語言治療、心理輔導等。而在這架構內，我們需要評估他們家庭能否承受壓力、有何需要、以及遇遭的環境因素等。

由於這些兒童的成長過程很多時十分脆弱，故此持續照顧變得異常重要。兒童在過度期間往往十分容易受到傷害，所以在美國便有强調設立個案主管（Case Manager）來統籌並爲弱能兒童提供一個全面和持續的照顧。這些職位的人士可以來自任何學科訓練，但他們需要有特別的專長去設計照顧計劃，包括鼓勵家庭成員間的聯繫、提供服務渠道和確保兒童得到有效的醫療照顧等。

（五）工作人員培育

最後我希望討論的課題是有關工作人員的培育。我知道，爲香港來說這是一個重要的問題，但這問題實在是世界性的。大概二十年前在美國一些大學內設立了跨學科的弱智／弱能兒童服務及工作人員培訓中心訓練，目的除了結集一羣對弱智服務有興趣的學者，以求集思廣益外，也爲有志服務弱能兒童的人士提供了專業服務訓練的機會。

二十年來，弱智／弱能兒童服務的確有了長足的發展，但由於我們對弱智／弱能服務有了新的理解，更令我們感到人手不足。我們不單需要某個數目的專業人員，我們更需要他們有一些特定的技能。試想一個以家庭爲中心，並且兼顧智育與羣育的全面性弱能／弱智兒童服務，所要求於工作人員的，是他們必須有多方面的才幹。每方面都要求一套截然不同的知識、態度和技巧。而爲個案主管來說，他們的訓練就得更嚴格。

跨學科的「早期介入」服務自有其優點與弱點。其中最大的困難是如何去建立一個有連貫性的訓練系統——因爲每個學科都有其獨特的行政方式、資証要求（certification）和特性。舉例來說：在過去十年間，我曾嘗試爲見習兒科醫生提供一個訓練計劃，使他們日後能爲弱能／弱智兒童及其家人提供完善的服務，其間所遭遇的困難便不少。又以訓練幼兒工作來說：目前在美國不少人都支持幼兒工作者與教師的訓練要分家。要訓練0至3歲的幼兒工作者是毫不容易的，我們還得看看能否有足夠的人願意加入這個專業。至於3至5歲兒童的教師，我們不可能訓練大批的專業人員，故此我們只能爲教師提供在職訓練，灌輸有關處理弱智／弱能兒童的知識。這種訓練模式與上文所提及的兒童發展觀念基本上是一致的。我們訓練教師如何將課室的結構與課程，配合弱能／弱智兒童的需要，以及如何及早察覺問題，向專家求助等。

結論

弱能／弱智兒童服務工作，實在是非常重要的工作。因爲我們愈來愈肯定，幼兒階段所學習到的，後期不容扭轉過來。我們也知道，早期介入可以避免發展退化；反過來說，沒有系統性的介入服務，退化是極可能發生的。

我們從上文亦見到「早期介入」服務無論是在觀念上或是實質上，仍是在轉變中。現在我們對家長—工作人員的關係有了新的看法，也有改良了的課程——一個更著重兒童發展，並且兼顧智育與羣育的課程。藉著對理論的反思，對實際工作的評估，以及培育工作的加强，我們希望我們所提供的服務更能精益求精，日日進步！

EARLY IDENTIFICATION, ASSESSMENT AND PLACEMENT

Rose Mak

In response to Professor Guralnick's speech, I would like to comment on our local system of early intervention services as a doctor working in a multidisciplinary child assessment centre in the HK Government Department of Health.

I can safely say that colleagues involved in the rehabilitation of disabled preschoolers fully recognise the need for early intervention. As far as I can gather from the 1977 White Paper on Rehabilitation and the subsequent reviews of the ensuing Rehabilitation Program Plan, the Government also accepts that there is a need for early intervention in the rehabilitation of disabled children. This is important, as a look at the present preschool services shows that the majority, if not nearly all, are either organised by the Government or sponsored by the Government.

I shall comment on the services for Detection, Assessment and Placement, as these are the areas that I come into contact with in my work.

Early Detection

This is the first step towards early intervention. In Hong Kong disabilities are usually detected through one or more of the following:

(1) Newborn screening and examination
(2) Developmental Screening Tests in Family Health Service Centres
(3) Contact with doctors
(4) School teacher suspects that the child has a disability
(5) Parents suspect that the child has a disability

The majority of babies are born in hospitals or maternity homes of the Family Health Service. Newborn babies are screened for hypothyroidism and Glucose-6-phospate Dehydrogenase deficiency, the former for early treatment and the latter as basis to advise care-givers not to give certain Chinese herbs to affected babies so as to prevent the precipitation of jaundice in the newborn.

Newborn babies are also examined for congenital anomalies so that treatment can be started as soon as possible.

As the babies develop, they can attend routine Developmental Screening Tests at ages 9 months, 3 years and 5 years at the Family Health Centre with which the child is registered. These are simple tests carried out by trained nurses. Areas screened are: Vision, Hearing, Gross motor, Coordination, Language and Social skills.

For children who do not attend the DSTs, their disabilities may be detected by doctors with whom they come into contact. Many children 'at risk' or with systomic illnesses are already closely followed up by paediatricians who often carry out simple developmental assessments as part of their management plan.

Of course there are some children whose disabilities escape detection until they attend school and are then picked up by their teachers.

Not long ago, I saw a child whose hearing impairment went undetected because his mother did not suspect it and did not bring him for routine DST.

The little boy was bright and healthy. Although he had meagre and often unintelligible speech, his mother thought that he would be just like his elder brother who had spoken late but had apparently recovered well without intervention. It never occurred to his parents that he was not hearing well. They were too busy working anyway to bring him for routine checkup at the Family Health Centre. He was finally brought to medical attention because his kindergarten teacher urged his mother to do so. It turned out that he has bilateral moderate severe sensori-neural hearing loss.

It is obvious that central to the various ways whereby disabilities can be detected are the parents themselves. It is through them that their children can come into contact with any one of the medical/para-medical personnel involved in the detection of disabilities.

We have a saying "Treat illness when it is still early" and parents are generally very alert to physical illnesses and physical anomalies. There was a mother who had just at that instant delivered her 3rd baby. As was routine, the nurse was holding up the baby to show its mother the sex of the baby. During this brief instant, the baby's eyes must have opened because the mother claims that she saw a white spot in the baby's eye. It had been quite a number of hours afterwards before medical staff could successfully confirm what the mother saw. The child had a congenital anomaly which required early treatment.

It would be a great help towards early detection if parents can apply this alertness for physical conditions to disabilities as well. For this to happen, I believe that parents must be informed about disabilities and their possibilities, the importance of early intervention and benefits of early intervention.

I would thus strongly support not only a public awareness program to focus on early intervention, but also public education on child development, including psychological aspects of child development. Only then, can early detection be effective.

Assessment

When a child is deemed to have a disability, he is usually referred to one or more of the following for assessment depending upon the type of disability detected:

(1) paediatricians & other specialists
(2) Education Department Special Education Service Centres
(for auditory & speech problems only)
(3) child assessment centres

The average parent and all doctors usually have no difficulty finding the most appropriate medical specialist to confirm & evaluate a particular disability, e.g. visual impairment.

However, children & families who have more complicated problems, e.g. a multiply disabled child in a disadvantaged family, will be more difficult. These children are often referred to a child assessment

centre for comprehensive evaluation. There are currently 3 such centres. Procedures are similar. There are 4 steps to assessment:

1 — screening & intake,
2 — the evaluation itself,
3 — case conference among involved team members,
4 — case conference with parents & follow-up.

The multidisciplinary team in these centres consists of:

developmental paediatrician	physiotherapist
health nurse	occupational therapist
clinical psychologist	audiologist
social worker	speech therapist
and others	

Interdisciplinariness is indeed an asset as well as a liability. A coordinated team approach is obviously more likely to be successful if one attempts to solve the problems presented by families of children with complex developmental disorders. However, simply bringing together a group of 'child development specialists' do not automatically create a functional team. Each member must have respect and understanding of other disciplines and appreciate the interdependence of each profession on the other for the solution of complex problems. Teamwork requires mutual trust and respect for professional competence. This is difficult for fledging disciplines.

For the paediatrician, the jump from traditional clinical paediatrics to developmental paediatrics in a multidisciplinary team is often very difficult. In HK, tradition puts the doctor into the position of leader as well as case manager. Since developmental paediatrics is essentially a multidisciplinary specialty, the paediatrician must be able to understand the techniques and terminology used by his colleagues, both medical & non-medical.

Child development, like other aspects of paediatrics, is a rapidly advancing subject, but many of the most relevant new ideas and concepts originate in disciplines such as psychology, child and family psychiatry, education, language development, etc. which are not familiar or easily accessible to the paediatrician. Furthermore, in contrast to most other medical specialties, the paediatrician working with developmental disabilities, often finds that his role, although important, is subsidiary to that of his colleagues.

There is currently no training program to equip doctors with the skills to cope with their multi-faceted role as developmental paediatrician, team leader and case manager. Professor Guralnick has mentioned the difficulty in training doctors in the field of paediatrics as well as for other disciplines to equip them for services as well as for interdisciplinariness.

In HK, the field of rehabilitation is relatively new. It is only in the last 5 years that we begin to have colleagues in so many different disciplines. Many of us are trained overseas e.g. paediatricians, speech therapists, audiologists, and the local scene poses not only language difficulties. I feel that the training programs we provide are just like the first generation early intervention programs, and it will take time and experience before they become 'relationship-focused'.

In spite of our qualms and concerns regarding training, the multidisciplinary child assessment team is very much in demand. As far as the centres in the Department of Health are concerned, the waiting time

for the evaluation itself is long and unsatisfactory. In order to repair this state of affairs, the Department is going to establish five more centres in the next ten years.

As for the training of staff, there is hope that one day paediatricians (if not other disciplines) can be trained along the lines as mentioned by Professor Guralnick. Paediatricians are now already trying to agree to core competence and to draw up specific curricula. I look forward to the establishment of our local Academy of Medicine in 1991. This will be a first step towards systematic continuing education and training for junior doctors as well as existing ones.

Placement

Finally, I would like to say a few words on preschool special education and training placements. Currently available are:

(1) Early Education and Training Centres
(2) Integrated program in Child Care Centres
(3) Integrated program in Kindergartens
(4) Special Child Care Centres
(5) Preparatory Classes in special schools

Access to these different programs & placements is through referrals by social workers to the School Welfare Department's Central Referral System (CRS) set up only 18 months ago. Parents with disabled preschool children can contact any social worker for information on these services.

(2) - (5) are daily programs in nursery/school setting and require assessment reports for recommendation.

I would particularly like to mention the EETCs. It is at these centres that early intervention in the form of a comprehensive infant stimulation program is provided. Anecdotal reports from parents show that most parents find the service very helpful and would like to continue with the program even when their children have progressed sufficiently to be discharged or to attend other placement programs. There are at present nine centres, five of which are operated by the Heep Hong Society. For home-bound families, there is also a home-based outreach program from the EETC. Currently, this particular service is only offered by the Heep Hong Society.

Although we have not made any systematic study, it is my impression, and also the impression of many of my colleagues, that children who have attended these special preschool placement programs appear to be better socially and in visuo-motor skills. The parents (we often only see the mothers) also appear happier with their children.

In summary, I have briefly described how in HK a child's disability can be detected, where that disability can be assessed and the types of placement that are available for rehabilitation. Preschool rehabilitation services in Hong Kong, although still very far from the ideal, have at least made some progress since their beginning. Most important of all, it is for the parents to make use of these services. There is therefore the need for promoting public awareness of disabilities and the rehabilitation services available.

When early intervention is possible, then the second generation programs Professor Guralnick mentioned will undoubtedly be the way for the future.

PARENTS' ROLES AND INVOLVEMENT IN THE TRAINING OF HANDICAPPED CHILDREN

Joseph Lau

Dr. Michael Guralnick talked about the second generation of early intervention programmes which have focused their attention to the fostering of natural, supportive and reciprocal relationships between parent and child. The key to this is that parents should have the opportunity to gain confidence over time and develop skills which improve their ability to interact with children. World-wide Children programmes tend to have as a central focus the empowerment of parents and demonstrate that parents can create new kinds of family and community self-help based on local realities. It is high time that we should examine the roles of parents and new perspectives on parent-professional relationships in early intervention.

We have long recognized that children cannot learn in abstract terms; for them the process, to be effective, should be consonant with the rest of their daily experience. They must be brought up in loving and caring environment, in which teachers and parents offer secure relationship. At the core is the development in children of a healthy self-concept which in turn depends upon positive interaction between children and significant adults in their lives. The role of the family, particularly of the mother, is critical. Mothers with poor self-concept will pass this on to their children. The healthy development of young children can best be achieved by fortifying families, particularly mothers, in their tasks as the child's prime educators. Unfortunately, parents of handicapped children are those least likely to recognize their own value in this aspect. Parents may not recognize that their role as a primary educator is independent of their levels of formal schooling.

A variety of experience has demonstrated the importance of parental involvement in educational efforts with the young handicapped child. Education at this early stage, without the participation and understanding of parents and family members, is limited in its effects. Many regard the adequate involvement of parents and family members within the early intervention process as adding an important quality dimension to the child's education and habilitation. It has a reciprocal benefit on adults themselves. particularly as regards to the development of self-confidence and competence in meeting the needs of their children.

The fundamental goal of parent and child-directed intervention programmes should be to enable the mother learn how to build a mutually rewarding relationship, based on accurate observations of the handicapped child's growth and capacities. Without such an affective base to the relationship, children cannot derive maximum benefit from 'educational' experiences. In simple terms, the aim is the generation of pleasure in the relationship, pleasure for the parent in living with the child. This leads in turn to the mother's heightened self-esteem, obviating her guilt feelings that the child is burdensome and the fear that she is not able to cope.

Whether parents are indeed the prime educators is not a debatable issue. The question, however, is the degree to which this applies in individual cases and the kinds of support systems needed to enable the role to be discharged optimally. The issue then is how best parents can realize their role. This consists of the development of strategies to enable parents to achieve power and use it constructively. Fundamental to this is the need to foster group awareness and organization among parents. Through such procedures parents should learn not only to use the available services or institutions to benefit their children but also exercise the right to decide what is most advisable for their children's development and their own.

Even when it is accepted that parents can be important educators to their children, it is necessary to strengthen their efficiency and to ensure that they gain in confidence. Parents often believe that professional educators are better equipped to educate and readily defer to the professional's expertise. Families may have previously been exposed to paternalistic or charitable initiatives by social agencies of various kinds. Some of these agencies have in fact encouraged local people to be passive. This makes it difficult for families to understand the meaning or purposes of programmes which operate on the principle of parental empowerment and involvement. They may indeed prefer dependence upon the professional which removes the need to initiate changes in their own lives. The process of parental involvement is more difficult in families with single parents, when there is sickness and when parents are too closely engaged in the struggle for existence to devote time to their children. Effective intervention programmes must seek to alleviate the effects of these and other inhibiting factors.

The education of the handicapped child is a shared task, a coming together of many disciplines. Although at theoretical, and even at policy levels there is growing understanding of the notion of partnership, this comprehension often does not exist in the bureaucracies which execute policy, nor in many professionals working with children. Professionals have to recognize that parents can and do educate their children. The problem is to define the type of help, the tools, and how to apply them.

This requires professionals with a new repertoire of skills and alert to the problems of working with parents of different backgrounds. Different qualities are demanded of the professional as the role of educator is taken up more widely. The cardinal point is that professionals become adult educators able to work with parents and monitor activities. The role of the professional is not to teach the parents. The relationship, at best, is complementary but not hierarchical. The importance of the link between the professional and the parents is clear. If the matters presented, raised or encouraged by the professional are relevant and interesting, the parents will be likely to adopt them. Thus it is important to design and make learning materials, based on an intimate understanding of the home and the child's developmental level and behavioral style. The professional worker should assess the home conditions so that they do not impose unrealistic targets for parents and appreciate the context in which the mother has to work. Building parental responsibility and confidence is a very delicate business. It requires non-instrusive, supportive skills which deal with stresses, emotions, relationships and attitudes of families. They demand counselling skills and knowledge of parental adaptation and coping, which must be a priority in in-service training.

Teachers or child care workers need to be convinced of the importance of working with parents. Since they are often over-burdened with a heavy work load they may view parent involvement as an additional task. Early intervention programmes must allow time for the teacher to work with families. This should be an integral and normal part of the teacher's job.

Prevailing cultural patterns have, in practice, identified women as the prime caregivers of children. Male involvement has been minimal. Since society rarely expects the father to contribute to the rearing of infants, they often live up to these negative expectations. It is very difficult to change fathers' involvement in the care of children unless their consciousness is raised so that involvement with their children becomes a rewarding experience. On the relative degree of participation by husband and wife in activities involving the child with handicap, evidence suggests that only a minority of fathers are significantly involved. I believe that father's role can be conducive to helping young children. There is a need to concentrate in early intervention programmes on working with fathers and to enrich existing knowledge and understanding of how fathers can fulfil their role and provide positive parenting models.

It has been argued that our existing services and programmes currently focus upon the health and education of children with handicaps, without giving serious and systematic attention to the social and emotional needs of the family as a whole. The primary focus of our early intervention programmes has been developmental or educational in nature, and teachers are trained exclusively in helping parents to

develop their children's skills. Consequently, psychological support of a more general nature for the family as a whole is only a possible by-product of the system, although awareness of the need for more general counselling is being expressed. There is reasonably firm evidence that all families with a handicapped child are subject to increased stress and strain and many families we came across were in particular need of social and emotional support.

In the past few years, we have seen the formation of various parent associations for children with special needs. The parent associations have generally become enmeshed in an advocacy role in efforts to secure necessary and adequate special training opportunities for their children. However, this is probably the beginning of the parents' involvement in exercising their rights and a voice in the education system serving their children.

My bias is that the parent associations should expand their self-help or mutual support dimension on an organized basis. Surveys have shown that most parents want to have contact with others whose children have similar disabilities to their own. Support can be provided by a group of volunteer parents who themselves have children with handicaps. In some circumstances, motivated parents may receive a small stipend for their service. The type of support offered can be described as mutual support counselling. This is support provided by people who have lived through similar experiences to those they are trying to help. The benefits are mutual in that parents who seek help have the advantage of talking to a person with similar experiences, while support parents find that by helping others they gain insight into their own situations. If professionals are engaged in the training of support parents, a parent-professional relationship can form the basis of such a scheme. By training parents to help other parents, professionals are assisting in the development of a support system which will meet many of the parents' needs. Such early support can help to promote parent-child bonding, positive attitudes and productive help-seeking behavior in parents. I hope some of you would see it as a priority to work towards developing an organized support network for parents of handicapped children that is effective and easy to operate.

To conclude, I like to call on all of us, who are providing services to families of handicapped children, whether in education, health or welfare, to reconceive our role. By stressing and accepting the importance of parents, professionals take on a more sensitive and skilled partnership role, using our professionalism to bring out skills in others. We must ensure that handicapped children and their parents are given every opportunity to develop their potential ability to its limits.

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父母在訓練弱智／弱能兒童所扮演的角色

劉啓泰

GURALNICK 教授的講詞，帶出了新一代的早期介入服務，其重點是集中於培養親子間原性的互勵互惠的關係，而其關鍵性的因素就是給與家長機會逐漸建立信心和與孩子交往的技能。全球性的育兒服務都傾向於把焦點放在家長可發揮的能力，並顯示出家長能夠創出以家庭或社區爲本的自助模式。因此深入探討家長的角色及從新的層次看家長和專業服務於早期介入的聯系，正是時宜。

我們一向明瞭到兒童不可能抽離現實的去學習，而學習的過程應與日常生活環節有一致性，才能有果效，家長及教師應提供可信賴的關係讓兒童在充滿愛心與關懷的環境中成長。目標乃是透過兒童與有關成年人的良好交往而培育出兒童健康的自我形象。家庭所扮演的角色，尤其是母親，是具有非常嚴重的影響力，自我形象低落的母親往往會傳授予其子女同樣的一個不健康的自我形象。故讓幼童健康成長的關鍵就是鞏固家庭，特別是母親，作爲兒童的主要教導者。但不幸的是弱能兒童的家長往往未能認同他們本身在這方面的價值，他們作爲主要教導者的角色與其學歷深淺並無關係。

各方面的經驗都顯示出對於家長參與弱能兒童的教育的重要性，早期教育的果效有賴於家長和家庭的參與及對弱能兒童的了解。家長及其家庭成員參與早期介入過程已被視爲强化兒童的教育及康復工作中的重要一環，對他們來說，早期介入的過程亦爲他們帶來了照顧弱能兒童的一份自信心和能力。

以親子爲主的介入程序，基本目標應爲讓母親透過對兒童之成長與能力的準確觀察去學習建立互惠的關係。若是欠缺這種感性的關係基礎，兒童則無法從教育經驗中取得最大的裨益，簡而言之，目標是達到親子之間愉快的關係、和諧的相處，繼而令母親的自我形象提昇，消除其感覺子女爲負累的內疚感及無能爲力的恐懼。

家長作爲主要教導者的角色是無可置疑，要探討的是家長在個別情況可以發揮的程度及所需的不同類別的支持系統，以期達到最佳效能，故問題在於如何使家長可以把教導者的角色發揮到淋漓盡致，其中一環就是有策略性地幫助家長獲得並運用其箇中能力，而基層工作是要培養各家長一種羣體的醒覺性及組織性，從中使家長不僅學會如何利用已有的服務提供，還可以領會到所擁有爲其子女權益而作決定的權利。

假若家長可作爲重要教導者的概念已被接納，但仍需要强化其效能及增强其自信心。家長往往傾向信賴專業教導者比他們更懂得教導他們的子女，於是毫不猶疑的將教導子女的一切委託於專業人士，某些家庭因曾接受一些「全面照顧」的社會服務，助長了他們的被動性，故對明瞭及投入「以家長參與爲本」的服務，自當困難重重。他們爲避免自身需作出因應的改變，而寧可倚賴專業人士去提供一切服務。

對於一些情況如單親家庭、家中成員患疾病、或日夕爲口奔馳的家長來說，「以家長參與爲本」的程序，更難推行，若要有效地推行，就得減低這些妨礙家長參與的因素。

教導弱能兒童的事工是需要由不同類別的專業分工合作達成。在理論上；或政策上的層面，都逐漸理解到各方面合作的需要，但這份理解並未完全達到行政架構的運作上或某些爲兒童服務的專業人士中，專業人士需認識到家長實在能夠並正在進行著教導兒童的工作，問題在於界定提供何種類別的幫助、運用的工具和如何運用等事項。

這個導向要求專業人士增加其爲來自不同背境的家長服務時的技巧和醒覺性，對專業人士扮演教育工作者這角色的要求亦漸被接受，其著重點在於負起成人教育工作者的任務和監察各項活動，其角色不在於教導家長而是與家長建立一種平等而相輔相承的關係，專業人士與家長互相聯系的重要性是顯而易見的，若專業人士所表達的、提議的和鼓勵的都是切題和富趣味性的，家長多樂於接納，因此，教材的設計需要切實的以兒童的家庭狀況、該兒童的發展程度、行爲模式等爲依據，否則對家長來說，該訓練程序流於不切實際，無法推行。幫助家長去建立起一份責任感和信心是一項非常微妙的事情，需要運用支持而不具侵擾性的技巧來處理家庭中的關係態度、情緒和壓力。爲應付這項工作，必須優先對有關輔導弱能兒童家長的知識和技巧方面提供專業在職訓練。

對幼兒工作者或教師來說，需要令他們接納家長工作的重要性，他們已有的工作量委實太繁重，因此容易視家長工作爲一項附加的工序，故早期介入服務的設計必須給予教師充份時間處理家長工作，並應該納入教師的整體性及經常性的工作範疇。

主流文化都認定了母親爲育兒工作的主要人物，男仕的參與保持在最低程度，既然社會期望如是，男仕似乎樂於如此執行，要改變現況談何容易，除非男仕們意識到參與育兒工作是一項富有滿足感的經驗，但從一些實據顯示，極少數父親曾經認真地參與過，我相信在育兒工作上父親的積極性是可以發揮的。在早期介入服務方面，實有需要注重以父親爲工作對象，加强現有對父親角色的認識和了解提供積極的家長模式以供父親仿效。

曾有爭論認爲現時弱能兒童的服務和程序只顧及兒童的健康教育，但對於整個家庭的社教和情緒上的需要，卻缺乏了嚴謹及有系統的關注。早期介入服務之要爲兒童的教育和發展而設計，教師訓練亦專注於爲幫助家長去發展兒童的各項技能，因此在過程中，家庭可能獲得的心理上的支持實爲一項副產品而已，雖然對於加强各方面輔導工作的需要亦有表達。無可置疑地家中有一名弱智兒童肯定增加不少壓力，特別需要羣體及精神上的支持。

過往幾年，數個弱能兒童家長會經已成立，他們大致扮演一個倡導角色，提昇給予他們子女足夠的特殊訓練機會，這大概是各家長爲其子女在特殊教育制度上爭取合理權益所踏出的第一步。

我則認爲這些家長會應在自助和互相支持的層面上有組織地發展。調查結果顯示出大部份家長希望能夠接觸其他弱智兒童的家長，使彼此能互相鼓勵，在某些情況下對於積極推動服務的家長，可以給予少量酬勞，這類型的支持可以稱爲「互惠輔導」，即是由擁有類似經歷的人士給予身處相同境況的人士支持和鼓勵，而雙方面均可獲益，受助者固然可以從傾談中得到益處，助人者亦因而獲得啟發，加强對自己情況的領悟。假若專業人士要提供家長訓練，使他們成爲支持者，那麼，專業人士與家長的關係是這項計劃的基石。透過訓練家長支持者，專業人士正協助發展一項符合很多家長所需的支持系統，及早的支持可促進親子的感情聯系，提昇家長的積極能度及鼓勵有建設性的求助行爲，我希望各位同意當前急務是發展一個爲弱能兒童家長而設的有組織性、有效和易運作的支持網絡。

作爲結語，我呼顲各位爲弱能兒童提供服務的同工，不論是教育、醫療、福利等服務，重新釐訂我們的職份，强調及接納家長參與教導弱能兒童的重要性，更敏銳和技巧性地發揮合夥人的角色，啟發他們的潛在技能，以保証弱能兒童及其家長獲得盡情發揮其潛能的機會。

POLICY AND CURRENT TRENDS OF SPECIAL EDUCATION IN HONG KONG

Ruth W. Lau

Introduction

Special education has a relatively short history in Hong Kong. The first special school which was a school for the deaf was established in 1935. It signalled the beginning of special education in Hong Kong. The main expansion in special education did not take place until the sixties. Despite this short history, Hong Kong has made changes in her policies and practices for the disabled in response to the changes in the views and trends regarding special education in other parts of the world.

The Policy

The overall policy objective for rehabilitation adopted by the Hong Kong Government is

> "To provide such comprehensive rehabilitation services as are necessary to enable disabled persons to develop their physical, mental and social capabilities to the fullest extent which their disabilities permit."

The central issues dealt with in this policy concern equal rights and opportunities between the handicapped and their non-handicapped counterparts. Perhaps it would be interesting to know how this policy comes into being. In fact, this policy is the result of the development of events occurring within and outside Hong Kong in the past twenty odd years.

The Special Education Section of the Education Department was set up in April, 1960 to advise and supervise a small number of special schools run by voluntary bodies. In 1963, the first Education Commission Report suggested that handicapped children required as normal a form of education as possible and should be given wherever possible, the chance to mix with normal children. This policy received support from overseas countries. In 1975, the United States Legislation (PL 94-142) and the Education Act of 1981 in the United Kingdom supported the concept of integrating the handicapped into the mainstream.

In August, 1972, the Hong Kong Government introduced free education. When a full variety of the needs of children become apparent as a result of compulsory education, there was a call for the establishment of a systematic policy on the provision of special education.

In 1976, a green paper, entitled "The Further Development of Rehabilitation Services in Hong Kong" marked an important milestone in the development of special education in Hong Kong. The green paper expressed the need to provide education for the disabled because they form a useful and productive source of manpower. It also argued on a financial point that "for every dollar spent on rehabilitation, we are gaining back 17 to 35 dollars." The goal of rehabilitation was spelt out as

> "To enable them to attain the fullest physical, mental and social capacity."

This laid the groundwork of the policy objective of our white paper in 1977 on

"Integrating the Disabled into the Community"

The aim of special education in Hong Kong is to provide children having special needs with education necessary to help them develop their potentials to the full, achieve as much independence as they are capable of and become well-adjusted individuals in the community. Our policy is to place such children whenever possible in ordinary schools so that they receive the fullest benefit of education from mixing and interacting with ordinary children in an ordinary environment.

Modern Trends in Special Education

We have set the stage for rehabilitation work and special education services. An international trading centre like Hong Kong would not remain unaffected by powerful trends and influences of most western countries. In the field of special education, integration has become a central focus of concern in recent years. With integration comes a group of other issues such as practicalities, curriculum, advisory staff and parent and peer attitudes. I shall deal with these issues and attempt to look at them in practical terms by outlining the nature and the extent of integrated provisions for preschoolers in Hong Kong.

Integration should not be looked upon as a new form of provision but a process whereby the education offered by ordinary schools becomes more differentiated to meet a wider range of pupils' needs. In the process of promoting integration, it is necessary to note that children need an education and integration is only a means to achieve the end i.e. an education so that they would be successfully integrated into the society.

In Hong Kong, wherever possible, at pre-school stage, children are integrated. If they are considered to be able to benefit from the ordinary school setting, they will enter child-care centres, nurseries or kindergartens just like the ordinary child. This step ensures initial acceptance on the part of the ordinary educational institute, its teachers, its other students and parents. Follow-up support, in the form of training programmes in language acquisition, communication skills, and social and emotional development are provided at the Special Education Services Centres to children who suffer from hearing impairment. Guidance, encouragement and training are also given to the parents so that they may be confident and competent in handling and teaching their hearing impaired children at home. Officers of the Special Education Section also pay regular advisory visits to promote effective integration and better cooperation among nurseries or kindergarten staff, special education workers and parents. Historically, children with other forms of disabilities are catered for in integrated child-care centres, special child-care centres like the Heep Hong Centres, the early education and training centres (four of which are operated under the auspices of the Heep Hong Society) and preparatory classes in special schools. It was in 1985 that the Education Department of Hong Kong was requested by the Working Party on Pre-school Care, Education and Training of Disabled Children (WOPSCET) to suggest practical means of encouraging ordinary kindergartens to accept disabled children. Educating pupils with special needs in ordinary educational institutes is not a question of importing special education to the ordinary school setting. Some specialist techniques which may be new to the educational institution may be required depending on the pupils' needs. A two-year pilot integrated kindergarten programme for disabled children was launched in 1985/86 involving nine non-profit making kindergartens. Each kindergarten taking 6-8 mildly disabled children could employ an additional teacher with training in kindergarten education to serve as a resource teacher.

The objectives of the integrated kindergarten programme for mildly disabled children were:

(a) to provide pre-school education to mildly disabled children in an integrated setting;
(b) to develop their potential to the fullest extent;
(c) to promote socialisation and integration among the disabled and the able-bodied pre-schoolers.

The basic features of the mode of operation of the integrated kindergartens during the pilot stage are summarized below:

Children served

(a) mildly mentally handicapped children
(b) mildly physically handicapped children with no serious mobility problems
(c) mildly visually handicapped children with no serious mobility problems
(d) mildly hearing impaired children

Staffing ratio

1 resource teacher to 6-8 disabled children

Teaching

Individual teaching
Teaching in small groups
Providing assistance to the disabled child in the regular class

Curriculum

Covering the 5 major areas of cognitive, social, language, motor and self-help

Training of Teachers

Resource teachers should have basic qualifications in kindergarten education. They were given further training through

(a) an orientation course for teachers of mildly disabled children in integrated kindergartens organized by the Special Education Section covering basic knowledge in working with disabled children, skills in planning, implementing and evaluating special teaching programmes, and activities for these children in an integrated setting,
(b) the "In-service Training Course for Child-care Workers and Kindergarten Teachers Providing Services to Disabled-preschoolers" organized by the Polytechnic, and
(c) workshops arranged periodically by the Special Education Section to consolidate teaching and management skills. Heads and regular teachers of the integrated kindergartens were also invited to attend part of the orientation course conducted by the Special Education Section to prepare them for the programme.

Sixty-three mildly disabled children who had received no less than six months' training in the programme by June, 1987, their parents, nine kindergarten heads, nine resource teachers, twenty-nine regular class teachers involved in the teaching of the disabled children and inspectors as well as educational psychologists involved in this pilot project made up the entire sample of evaluation of the programme.

The result of the findings indicated a significant difference in the number of tasks achieved by the disabled children in the five skills areas on a children's ability rating checklist designed to take data on the

performance of the children in the pilot project. After having received a mean training period of 13 months, the percentage increased in task achievement ranged from 26% to 43%. The areas with the biggest percentage increase were social and cognitive skills. The views of the kindergarten heads, the resource teachers, the regular class teachers, the parents and the inspectors were collected. There was a general move towards a high level of acceptance towards the second year and the kindergarten heads agreed that the programme had successfully achieved its stated objectives. The regular class teachers were unanimous in their views that integration with normal children had promoted social adjustment of the disabled ones and reduced their disruptive behaviour.

Full implementation of the scheme commenced in September, 1988. A coordinated procedure of referral and placement was established between the Social Welfare Department and the Education Department so that the demand of integrated places for disabled pre-schoolers would be constantly under reviewed. Based on a review of the demand for integrated places and of the readiness of the kindergartens to join the scheme, 120 places were provided in 1989/90. Further expansion of the scheme beyond 1989/90 will be considered on the same basis.

On completion of the pre-school stage, the handicapped child would be individually re-assessed by the educational psychologists. If the handicapped child is considered to be able to benefit from integrated education in an ordinary school setting, the child would be placed through the Primary one Allocation System into an ordinary school near his home. Thus the integration of disabled children into the ordinary school comes about naturally, and is not imposed externally on the school, thereby minimising problems of his being accepted by the school to which the disabled child is allocated. The child and his school would be provided with follow-up support to allow the integration to become effective. For this reason, a spectrum of intensive remedial services are operated for pupils with special education needs in ordinary schools.

It became very clear that parents wanted their children to be educated at ordinary schools. Some sought an active role in the education of their children while others eagerly accepted the opportunity to be involved in educating their children. The Education Department is concerned in improving the contact between the home and the school. A seminar was held last academic year for all the school heads of the local schools about working with parents as partners. A pamphet for parents of children with special needs is under preparation.

Conclusion

One of the contributions of integration is that children with special needs have the opportunity to attend ordinary schools, often they are schools in the neighbourhood. The disabled children study along with peers and are part of the local community. This does not remove the special needs but it places them in perspective. Integration, be it social, functional or physical is a means to an end. That end is to provide children having special needs with education necessary to help them develop their potentials to the full, achieve as much independence as they are capable of, and become well-adjusted individuals in the community.

AUTISM: CURRENT CONCEPTS, RESEARCH FINDINGS AND IMPLICATIONS FOR SERVICES

Michael Rutter

It is now nearly half a century since the syndrome of infantile autism was first described by the late Leo Kanner (1943). New approaches to the treatment of autistic individuals that are recommended today are very different from those that were favoured in the 1940's and 1950's (Howlin & Rutter, 1989). In part, the changes have come about as a result of clinical experience and of research findings on which methods of intervention seemed more effective than others. However, to a very considerable extent, the therapeutic changes have been a consequence of increasing knowledge on the nature of the condition of autism (Rutter, 1983 & 1988) and hence of the treatment methods that were likely to be helpful. That is as it should be. The planning of both individual programmes of treatment and the design of overall patterns of services needs to have a rational basis deriving from research findings on the pathogenesis of autism, of the psychological deficits that characterize the syndrome, the cause of the disorder and the factors associated with individual differences in prognosis, together with an evaluation of different methods of intervention.

Autism As An Organic Neurodevelopmental Disorder

Over the years all sorts of ideas have been put forward about the nature of autism and about its causation (Rutter & Schopler, 1987). Thus, at one time it was supposed to constitute a particularly early form of schizophrenia — a kind of functional infantile psychosis. It is now clear that that view was mistaken. Autism and schizophrenia differ in numerous respects and there is every reason to suppose that they represent quite different disease processes. Then, for a while, many psychiatrists viewed autism as a psychogenically determined "break with reality", brought about by hostile or neglectful patterns of parenting. Again, that view is now known to be mistaken. Secondly, child neglect and abuse can indeed lead to serious abnormalities in social and language development but these are of a kind that are very different from the abnormalities of autism. Moreover, numerous studies have shown that the upbringing of autistic children has usually been unremarkable. Autistic children are reared in homes of all sorts, good, bad and indifferent, just as are other children.

These outdated views have been replaced by a general acceptance that autism represents an organically based neurodevelopmental disorder involving basic cognitive and social deficits. Because this concept is fundamental to treatment approaches, let me outline a few of the most crucial findings.

The first indication that organic brain dysfunction was involved in many cases of autism came from the finding in our follow up study that about a quarter of autistic individuals developed epileptic seizures during adolescence (Rutter 1970), a finding subsequently confirmed by other investigations (Deykin and McMahon 1979). This occurrence was substantially more likely when autism was associated with severe mental handicap. However, the pattern of age of onset of epilepsy in autism differed markedly from that usually found in mental retardation. Whereas mentally handicapped children usually first develop epileptic attacks in early childhood, autistic individuals usually have their first attacks only during the teenage period or even early adult life.

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Since that first finding on the occurrence of epilepsy, there have been numerous other findings pointing to an organic basis. For example, autism has been found to be associated in some instances with conditions such as tuberosclerosis, congenital rubella and the fragile X chromosome anomaly (see Rutter 1988; Schopler & Mesibov 1987). It is necessary to emphasize that these medical conditions account for only a tiny proportion of cases of autism but the findings indicate the importance in all cases of undertaking the necessary physical examinations and special tests to check whether any of these, and various other, medical causes may be applicable. The likelihood of an organic basis is also shown by the finding that about a third of autistic individuals have a raised serotonin level in the blood. This is not a diagnostically specific finding as it also occurs in a similar proportion of cases of mental handicap and it is found in a variety of other neurological disorders. Its meaning remains somewhat uncertain at the moment but it is a finding that tends to be associated with some form of organic brain disease.

Finally, it should be added that neurophysiological studies have shown various abnormalities, and that structural abnormalities of the brain have been evident in brain imaging studies. Until recently, none of the these investigations had given rise to a very consistent set of findings. It was of course important that the evidence pointed to some form of brain abnormality but this did not have very direct treatment implications because the abnormalities seemed so varied and non-specific. In the last year or so, there have been claims that autism may be associated more particularly with abnormalities in the cerebellum — the area of the brain that has been traditionally associated with the control of balance and muscle coordination (Courchesne, 1989). It is too early to say whether or not this finding will hold up and it would be premature to base treatment planning on these findings. However, it is possible that during the years to come that with the very rapid advances that are taking place in neuroscience generally and in methods of investigation of brain structure and function, more precise leads may become available in the future.

One key point is evident now, however. That is, although the majority of autistic individuals show some degree of intellectual impairment and although there are many parallels between autism and general mental handicap, nevertheless, autism differs from mental retardation in several crucial respects (Rutter & Schopler, 1987). I have already mentioned the striking difference in the age of onset of epileptic attacks — early in mental handicap and later in autism. It is also apparent that there are some interesting and striking differences in the pattern of associations with causal medical conditions. Thus, Down's syndrome is the single most common cause of mental handicap but it is rare for it to be associated with autism. Similarly, cerebral palsy shows a substantial association with general cognitive impairment and with mental handicap but it is exceedingly uncommon to accompany autism. The strong implication is that the causes of mental handicap and the causes of autism, when they are known, will not be the same (although they may overlap to some degree). This is also evident in the neuropathological and the brain imaging findings. Severe mental retardation is usually associated with fairly obvious gross cerebral pathology. By contrast, that is not found in autism. Instead, the abnormalities tend to be subtle rather than gross and, also, they tend to be found in the cerebellum and possibly the basal ganglia, rather than in the cerebral hemispheres. It is not immediately apparent what treatment implications flow from these many differences between autism and mental handicap but it would be surprising indeed if there were not some important implications — at least with respect to medical-type interventions.

Genetics of Autism

Turning now to the question of aetiology, it is clear that genetic factors play a major role in autism (Rutter, in press). For quite a long time there was little attention paid to genetic factors because it seemed that autism so rarely ran in families. That is, the evidence showed that when one child in a family had autism, the risk of autism in other brothers and sisters was something in the region of 2 to 3%. That seems a very low rate and in a real sense, it is. However, from a genetic perspective, what is more important is that the rate of, say, 3% is very many times higher than the general population rate of approximately 3 per

10,000. Even if a rather broader definition of autism is used, the general population rate is still only of the order of about 20 per 10,000. In other words, the risk of autism in brothers and sisters is anything between 10 and 100 times the expected rate. Two other factors make the family data a most uncertain guide to genetic factors. First, for obvious reasons, it is unusual for autistic individuals to marry and to have children. Accordingly, even if the condition was strongly genetic, the usual vertical transmission in families is not to be expected. Secondly, because autism is such a major handicap creating substantial burdens for the family, there is a tendency for parents, if they have at least one normal child, to stop having further children once an autistic child is born. That means that the recurrence risk in siblings will be misleadingly low.

It was consideration of these that led to the first systematic twin study of autism undertaken by Susan Folstein and myself (1977), which showed a substantial genetic component in autism. Ann Le Couteur, Tony Bailey and myself (Le Couteur *et al*, 1989) have recently undertaken a further systematic, population based, twin study and this has confirmed the important genetic component. In brief, when the two twin studies are combined, about half of the identical (monozygotic) co-twins also had autism and about 90% had some form of disorder involving cognitive and social impairment, albeit not of a kind that fulfills the traditional diagnostic criteria for autism. In sharp contrast, none of the fraternal (dizygotic) co-twins had autism and just less than 10% had any form of cognitive and social disorder. What these data mean is that the heritability of autism is very high indeed — the figure being in excess of 90%.

Family studies undertaken by my colleagues and I (Macdonald *et al*, 1989) also point to a strong genetic component. As I have mentioned, about 3% of the brothers and sisters show autism but, equally importantly, about 15% show cognitive abnormalities of one kind or another (mainly specific delays in language) a figure 3 times that in controls. Also, about 15% showed marked social abnormalities of a type that seem to share some of the qualities seen in autism — something not seen in any of the brothers and sisters in the control group. As in the twin studies, it seems that what is inherited in autism extends rather more broadly than the traditional diagnostic picture of autism. Rather, it extends to a combination of cognitive abnormalities reflecting language and social abnormalities involving deficits in social reciprocity. In our own series, this combination of cognitive and social handicaps mainly occurred in individuals of normal intelligence, although it did include a few with mental handicap. It seems that what is special about autism is not the mental handicap as such but rather the particular quality of the abnormalities in communication and social relationships. The implication is that these need to constitute a specific target in our therapeutic endeavours.

Autism As A Neuropsychological Disorder

So far, I have emphasized different types of medical evidence showing that autism constitutes a neurodevelopmental disorder. It is necessary now that I give equal emphasis to the research findings showing that autism constitutes a rather special kind of neuropsychological disorder (Rutter, 1983). Three main points need to be made. First, it has been shown that the cognitive impairment that is often associated with autism is just as "real" as any other form of cognitive impairment (Rutter, 1979). At one time, it was thought that it was simply a secondary consequence of social withdrawal but is now known that it is not the case. IQ scores in autistic individuals function in much the same way as they do in any other group of people. They are strongly predictive of educational performance and later social adaptation; indeed, they are the best prognostic indicators that we have.

The second important point is that the pattern of cognitive disabilities associated with autism is distinctively different from that found in most cases of general mental handicap. In particular, the disabilities in autistic individuals are more likely to involve language related skills and they are more likely to involve deficits in sequencing, abstraction, and symbolic meaning.

Thirdly, in the last few years a range of studies has shown that autistic individuals tended to have rather specific social cognitive deficits that are likely to influence social relationships. The deficits that have been shown have taken two apparently different forms. First, as initially shown by Peter Hobson (1989) autistic individuals are impaired in their ability to make socio-emotional discriminations and to pick up socio-emotional ones. Other research has shown that they are similarly impaired in their ability to use socio-emotional signals. The second set of findings derives from investigations first undertaken by Simon Baron-Cohen (1989) and his colleagues. These showed that autistic individuals had a major difficulty in understanding what other people were likely to be thinking and in understanding their mental point of view. For instance, one experiment involved a scenario in which an object was hidden whilst somebody was out of the room. Most young children readily appreciate that when that person returns they are likely to look for the object where it was when they last saw it and not where it was in reality. That is because they understood that the person cannot possibly have known where the object was moved to since they were out of the room at the time and will not have been aware that it is has been moved. Autistic individuals by sharp contrast, seemed to lack this appreciation. This has come to be known as a lack of a "theory of mind".

Many questions remain to be answered about the nature of these neuropsychological deficits but might explain autistic individuals' social problem. Thus, it is not yet clear how far they are specific to the syndrome of autism and also it is not clear how these two apparently different types of cognitive deficit relate to one another. However, from a treatment point of view, it seems clear that many autistic individuals must be expected to have deficits in their ability to pick up social cues and to understand what other people are likely to be thinking. We do not know how far therapeutic interventions can diminish or circumvent this social cognitive deficit but it would seem important to take it into account in any efforts to improve autistic individuals' social functioning.

Follow Up Findings

Before turning to evidence on the evaluation of psycho-educational treatments, it is necessary to consider what is known on the "natural" history of the course of development of autistic persons. The findings of different investigations are in generally good agreement and the main points may be simply summarized as follows (Lotter, 1978; Rutter, 1970). First, provided that the diagnosis is based on adequate methods of assessment after the age of 3 years, scarcely any individuals entirely recover from their autism. Even those of normal non-verbal intelligence continue to show quite marked, albeit subtle, abnormalities in their social relationships and communication patterns. Thus, in our own follow up of some sixty autistic persons of normal non-verbal intelligence who are now adult, only one has married and scarcely any others have had any kind of sexual relationship. Secondly, however, the proportion who seek social relationships in adult life is much greater and one of the therapeutic needs is to help autistic adults deal with the social (and sexual) frustrations that are inherent in the discrepancy between what they desire and what they can achieve.

Thirdly, there are (regardless of treatment) huge individual differences in outcome. At one extreme, some autistic persons remain so severely handicapped that they are wholly dependent on people for the meeting of their day to day needs. At the other extreme, a minority are able to earn their own living (usually, but not always, in sheltered employment) and to live independently (again, usually but not always, in a setting that provides a minimal level of shelter or support). It should be noted that this means that even in the absence of specific treatment, some autistic individuals improve greatly and make very considerable social progress.

Fourthly, as I have already noted, the outcome is substantially predictable on the basis of the level of cognitive and language handicap as measured in the later preschool years. The outcome is worse in

those with a non-verbal IQ below 50 and who fail to gain a useful level of spoken language by the age of 5 years. Conversely, the outcome is best in those with a non-verbal IQ above 70 and who have gained communicative language by the age of 5. Fifthly, at least as measured up to now, outcome is not related to the autistic child's social and family circumstances. On the other hand, anecdotally, it has appeared that many of the autistic individuals who have had the best outcome have had parents who have shown unusual persistence in getting services for their child and who have been dedicated in their dealing with difficulties.

The last point to make about follow up is that it is evident that at least in the mildly handicapped autistic individuals, improvement can continue well into early adult life. In our own longitudinal studies there are many examples of autistic persons who were not employable at the usual school leaving age but yet who subsequently, in their mid twenties, obtained and held jobs and who went on to semi-independent living. I should add that, in planning treatment, we need to recognize that autistic adults often suffer from other psychiatric problems. Thus, it is not uncommon to see associated depressive conditions — some of which seem to be related to frustrations and social difficulties but some of which seem to have a more endogenous bipolar quality. It is also clear that some autistic individuals develop conditions such as obsessional disorders and multiple tics. Treatment plans need to take these into account.

Some Therapeutic Claims

Against that background I need to turn now to what is known on the efficacy of various forms of therapeutic intervention. Before considering the behavioural and educational methods that constitute the mainstay of current treatment approaches, I need to say a word or two on some of the supposedly specific interventions for which strong therapeutic claims have been made. In the medical arena, these include the use of vitamins, dietary modifications of various kinds, and the administration of the drug fenfluramine. With respect to vitamins, the main claims have been made for the use of a combination of the vitamin B6 (pyridoxine) together with magnesium (Rimland, 1987). There have been several systematic studies which have claimed to show significant, but rather modest, benefits in some children. It is certainly clear from the evidence that the results are far from dramatic and indeed there is some doubt as to whether the effects are really a function of the vitamins. There is no specific rationale for using vitamins in autism but the treatment stems from the general concept that many medical conditions supposedly benefit from giving them in very high doses. My own view is that the benefits are too small and uncertain to warrant recommending this form of treatment, especially as there may be some risks in giving vitamins in the very large amounts that are recommended (Gaultieri *et al*, 1987).

Much the same applies to the attempt to modify autistic behaviour through modifications of the diet — usually through the elimination of food additives of various kinds (Raiton, 1987). There is no evidence that this makes any significant difference to autistic problems. It probably is the case that a few children have a specific intolerance to various common elements in ordinary diets and it is known that this intolerance may lead to various allergic type medical problems and perhaps to restlessness and inattention. The problems of getting ordinary children, let alone autistic children to adhere to the extreme dietary control necessary to deal with this intolerance of certain foods is very considerable and once more, this is not a treatment to be recommended for the treatment of autism. If parents have noticed that their child's general behavioural difficulties are worse with certain foods, it may be appropriate to try eliminating these foods from the diet. This is on the common sense approach that, so long as a balanced diet is maintained, the elimination of these few specific foods will not do any harm and just conceivably might do some good. But, if this is done, it should be done without any expectation that it is going to make any difference to the basic handicaps of autism.

The third medical treatment is the drug fenfluramine. This is an appetite suppressant drug that leads to a lowering of serotonin levels in the blood. That I have already mentioned, about a third of autistic

children do have raised serotonin levels. This form of treatment was introduced with strong claims but there are now many controlled trials that have shown that the drug makes no difference to most autistic children and such very limited benefits as are occasionally seen do not affect the basic handicaps (Aman and Kern, 1989; Campbell, 1988). Moreover, in so far as there are any benefits from the drug, they are not related to the reduction of serotonin levels. This drug has been shown to have toxic effects in animal studies and it remains quite uncertain whether or not there are potential toxic effects in its use in humans. Because it does not do much good and because it just might do some harm, it is not a treatment that I would recommend.

On the psychological side, the two main treatments for which quite strong claims have been made are the highly intensive operant conditioning methods used by Lovaas and his colleagues in California, and so called "holding therapy" in which children are forcefully held for periods up to an hour and a half in an attempt to provoke, and then control, rage (Howlin 1989; Richer and Zapella, 1989). In 1987 Lovaas published a report that nearly half of 19 children in his experimental treatment group "achieved normal intellectual and educational functioning" and furthermore that these "recovered children showed no permanent intellectual and behavioural deficits and their language appeared normal". By contrast, this was so for only 2% of his control group. There are various design limitations in this study and doubts have been raised about the validity of the findings. You will appreciate that the claim that half the treated children "recovered" contrasts very sharply with the otherwise universal finding that almost no autistic children recover from their condition. While the methodological reservations are serious, they do not necessarily disprove Lovaas's claims. Nevertheless, they do raise the real possibility that the astonishingly good outcome may well have been a result of a combination of misdiagnosis at a very early age (the children were very young; a mean age of 32 months) and inadequate follow up assessment. As I will describe in a moment, there is evidence from other studies that behavioural methods of treatment are worthwhile. The scepticism felt by many of us concerns the quite unusually dramatic nature of the changes claimed by Lovaas. In view of the fact that his findings are so totally out of step with the rest of the literature, there needs to be considerable caution in accepting them at their face value until they have been replicated by an independent research group.

The Tinbergens (1983) have been powerful advocates of the holding therapy methods practised by Welch (1983) and Zappella (1983). The title of Tinbergens' book, 'Autistic Children: New hope for a cure' reflects the strength of the therapeutic claims. However, controlled evaluations of this method of treatment have yet to be undertaken and it is clear that, so far, the claims far outstrip the supporting evidence (Howlin 1989). There is nothing particularly controversial about the notion that autistic children should be held firmly when they get into a severely distressed or agitated state. This may well be quite reassuring as a means of bringing about control. What is more controversial is the notion that children should be provoked into exhibiting rage in order that they may then be held. The rationale for that seems to me to be so implausible and, the approach so contrary to the usual methods of dealing with children, that I am unhappy to recommend the approach.

Modern Behavioural and Educational Methods

Let me now turn to the evidence on the evaluation of the more usual methods of behavioural and educational intervention. The effects of systematic education were examined by Bartak and I in a comparison of the progress of autistic children in three very different types of unit (Bartak & Rutter 1973; Rutter and Bartak 1973). The results showed that both scholastic and behavioural progress was significantly better for children in the unit providing large amounts of specific teaching in a well controlled classroom situation. Progress was least good for those attending a unit run on permissive lines with children allowed to set their own pace and with an avoidance of behavioural control by staff. This was a non-experimental study in which it was necessary to make statistical adjustments for differences between the units and the

characteristics of the children admitted to them. Inevitably, this design, (the only practicable one in the evaluation of existing special schools) provides less secure findings than those based on controlled experiments with random allocation to units. However, it has the merit of assessing communication as it actually occurs in the community, rather than in highly specialised experimental facilities. The confidence to be placed on the results of this study must be judged on the basis of a consistency and coherence of the findings as a whole and on the extent to which the between — unit differences hold up when comparing like with like. On all counts it is highly probable that the results are valid, especially as the findings are consistent with the evidence from shorter-term well-controlled experimental studies (Clark & Rutter 1981; Schopler *et al* 1971). We may conclude that the teaching of autistic children needs to be systematic, structured and well adapted to the needs of the individual child. Given that approach, special educational treatment can make a real difference to outcome. It does not overcome the children's basic handicaps and there are large (essentially predictable) individual differences in response, but the results are demonstrably worthwhile.

The second evaluation concerned the longer-term benefits of an intensive home-based behaviourly orientated treatment programme that was compared with a more traditional out-patient approach (Howlin & Rutter 1987). The findings showed that the children in the home based programme made significantly better progress in both the short-term and the long-term. Again, the comparison relied on careful matching of the groups and on statistical adjustment for any differences that remained in the intake characteristics of the children to the two forms of treatment. However, the closeness of the matching and the extensive systematic measures of children's progress over time provide good evidence on the validity of the comparison. Several crucial points emerge from the findings. First, the results are convincing in their demonstration that treatment does make a worthwhile difference and that the behavioural methods are truly effective. Secondly, however, it was striking that the benefits were greatest for non-specific behavioural problems (such as fears, tempers, aggression and bed wetting) and least for language skills, with no effect at all on IQ. Treatment resulted in better social usage of language but not in any differential increase in language competence. It is important to emphasize this limitation of treatment, because the results of short-term evaluations suggest much greater benefits. The point is that our findings, like those of others, indicated marked short-term gains but these tended to be followed by much more modest longer term benefits.

Thirdly, there were huge individual differences in outcome. The most handicapped children made the least progress in spite of a comparable investment of therapists' and parents' time and energies in treatment. The outlook was especially poor for mentally retarded, mute school age children without babble, imaginative play or understanding of language. Appropriate treatment for this group can substantially reduce behavioural disturbance and, in so doing, improve social functioning. However, such children are unlikely to gain useful language or acquire self reliance — even with the best treatment. Conversely, the outlook was particularly good for children with a non-verbal IQ in the normal range who showed evidence of appreciable language skills. Note that the most able, least handicapped children in the control group also make good progress; but those in the home based behavioural treatment group did better.

Fourthly, an independent investigation to assess parental satisfaction a year or so after the treatment programme finished, confirmed its value (Holmes *et al* 1982). In other words, not only did the treated children show a better outcome on objective measures but also the parents saw the benefits as worthwhile. However, once more a caution is necessary with respect to the persistence of effects. Many parents experience difficulties in applying what they have learned when faced with new and different problems which the children developed after the programme came to an end. The implication is that most families require a degree of continuing professional support although it is usual for this to be necessary only at a much reduced level.

Finally, through a series of within-group comparisons and individual case studies using multiple baselines and the like, we sought to determine whether the treatment benefits were specifically due to the

particular behavioural methods employed (Howlin & Rutter in press). This is no easy matter when dealing with a complex, multi-faceted treatment programme but the evidence did indeed suggest that the benefits were related systematically to the interventions employed. In particular, they suggested that the children's gains were associated with the degree to which parents were able to modify their ways of handling in the desired direction.

Principles of Behavioural And Educational Treatment

The next issue that requires consideration is the elements necessary to make up an effective treatment programme. These have been considered in some detail in a paper of mine in 1985 (Rutter, 1985a) and in the book written with Patricia Howlin (Howlin & Rutter, 1987), and it is possible here to note only a few key points. First, there is no one technique or even a single set of principles. The methods that have been shown to be effective encompass a wide range of behavioural and educational methods broadly based on learning principles but incorporating those based on operant techniques, classical conditioning, modelling and other types of learning. For example, the principle of "graded change" has proved helpful in dealing with abnormal routines, rituals, pre-occupations and attachments (Marchant *et al* 1974). The general notion is that in order to alleviate the problems associated with stereotyped behaviour, progressive change may be introduced by means of a series of small steps, each of which is sufficiently minor to be acceptable to the child but which, over time, amount to a major alteration in behaviour. Another useful approach is to teach skills that enable children to cope successfully with situations that have hitherto given rise to frustration, distress or blocks on learning. Environmental manipulation may be worthwhile in achieving ways of avoiding situations of difficulty. Reinforcement techniques, too, may be valuable in rewarding the child for positive behaviour and in removing rewards from behaviour that needs to be diminished.

The second point is that the treatment program needs to be based on a detailed and accurate diagnostic appraisal of the child's assets and deficits and of the environmental circumstances that influence his or her behaviour. This appraisal needs to include several essential elements. It is necessary to have a good assessment of the child's developmental level in relation to non-verbal and language skills in order the treatment may start at the right level. A skilled, psychological evaluation is indispensable for this purpose. It is also important to obtain a detailed picture of the child's behaviour in different situations; this should include both the positive and negative aspects. Most crucially, there must be a systematic functional analysis of the behaviour — meaning an analysis of the preceding and succeeding circumstances that are found to increase, or decrease, the likelihood occurrence, persistence or diminution of particular maladaptive behaviours.

The third point in planning treatment is that it needs to focus on the child's behaviour as manifest in his or her natural environment at home, at school and in the community. Research has shown that there are major problems in obtaining generalization of benefits from one setting to another although there are techniques for aiding generalization (Handleman & Harris, 1980, Holman 1979; Wahler *et al* 1979). The implication is that in-patient treatment, although necessary in some circumstances, has considerable limitations as a general approach. Rather, it is necessary, whenever possible, to work with parents in the community.

That naturally leads to the fourth point; namely the need to engage parents as co-therapists. This is because parents are the people with the most extensive engagement with the child over the greatest number of situations, and because, by the same token, they are most likely to know which procedures have and which have not worked.

The choice of schools is a crucial part of any overall treatment programme. It is not just a matter of making sure the child is in a school or class that specifically caters for autistic children. Such educational

facilities may well suit most autistic individuals but they will not be optimal for all and special schools and classes vary a good deal in their approach. What suits a severely handicapped mute child with an IQ of 30 will not be the most appropriate for a highly verbal child with an IQ of 120. The needs of each child must be considered individually in order to produce, as it were, an educational "prescription" of the scholastic requirements. Some autistic children will make most progress in a school catering for normal children or those with a range of minor disabilities; some will be best in facilities mainly designed for mentally handicapped children; and many will be best suited to a placement in some form of school or class specifically designed for autistic children.

A further crucial consideration is that it would be unhelpfully limiting to consider treatment solely in terms of behavioural and educational methods. In addition, it is necessary to ensure parents receive counselling on family difficulties and that they are helped to obtain other services (such as dental care, child care provision and holidays for the handicapped); that, where appropriate, they receive genetic counselling; that there is the necessary medical treatment for epileptic seizures or other associated medical conditions; and that pharmacological treatment for behavioural problems be used for when they are needed.

There is no specific drug treatment for the treatment of autism but drugs do have a place in the symptomatic treatment of behaviours such as extreme emotional reactions to frustration or marked overactivity or other forms of disruptive behaviour (Campbell *et al*, 1987). My own experience is that these are more often needed in adolescents and adults than they are in younger children but they need to be used occasionally with all age groups. On the whole, stimulant drugs such as dextro-amphetamine or ritalin, are not very useful when dealing with marked overactivity in autistic individuals in spite of the evidence for their efficacy in other groups. Various studies have shown that they may increase stereotyped behaviours and sometimes they lead to marked dysphoria and psycho-motor retardation. However, occasionally, stimulants do seem useful in markedly overactive autistic children of normal intelligence. One of the less toxic phenothiazines, such as thioradiazine, is usually the drug of choice. For reasons that are not at all well understood, many autistic children seem unusually sensitive to these drugs and often a relatively small dose is all that is required. They are mainly of use when dealing with the marked tension and agitation experienced by autistic individuals in frustrating situations. They do not remove the problem but what they may do is, as it were, take the edge off the negative emotional response and hence make the autistic individual's way of coping more adaptive and socially acceptable. Haloperidol has been shown to be of benefit in controlling markedly disruptive behaviour in autistic individuals and its use is occasionally justified because of that. However, it is a toxic drug with quite a high rate of side effects — particularly a dystonic reaction. A number of autistic individuals do have multiple tics and, as haloperidol is known often to be effective in the treatment of tics, this may be a situation in which the drug is especially indicated.

The use of drugs is of course focused on the reduction or elimination of maladaptive behaviour. It is important to emphasize that, as with any other developmental disorder, the first goal of treatment with autism must be to foster normal development so far as that is possible. That must mean the promotion of cognitive, language and social development as well as the facilitation of learning so that children may profit from the experiences they encounter. In years gone by, much of the focus of behavioural treatments has been on producing spoken language. Of course, that is desirable but the change that has taken place in recent years is that there has been an appreciation that it is not words as such that are most important but rather the facilitation of communication in social relationships more generally (Howlin, 1989a). With respect to social development it is known that ordinarily intensive personal interactions that are pleasurable, responsive and comforting to the child constitute those that do most to foster social development. The difficulty experienced by autistic children is that they tend to lack normal social approaches and, more especially, they lack responsivity to normal social cues. It is clear that a major focus in treatment needs to be the provision of structured interactions with social intrusion. It also seems sensible to make sure that the limitations in personalized care giving that tend to be inherent in an institutional upbringing should be avoided in order that these do not add to autistic children's problems. That means that, usually, it is best

to avoid long-term residential care in early childhood. Because it is clear that autistic children have basic social cognitive deficits that interfere with their acquisition of normal social relationship, it would seem likely that some form of direct teaching, involving social skills training, would be indicated. This is, perhaps, the area of treatment where least is known on the merits and demerits of particular approaches. However, recent research suggests that more use might be made of peer interactions than has been the case in the past (Lord and Magill, 1989). My summary of the experimental research findings, showing that many autistic children are very poor in making socio-emotional discriminations, in picking up social cues, and in understanding how other people think and feel, would seem to be relevant here. What remains uncertain is quite what form of direct teaching is likely to remedy or circumvent these deficits. Also it is unclear how much can be achieved by this approach. I suggest that the main message for the moment is that treatment approaches need to be concerned as much with autistic children's difficulties in understanding their social environment as in giving them the particular social skills to deal with interpersonal interactions and encounters.

A further major goal of treatment concerns the alleviation of family distress. The parents and siblings of handicapped children face many difficulties and carry many burdens, and this is especially the case with autistic children, many of whom are unresponsive and rewarding to be with, difficult to play and talk with and demanding in their needs for supervision, structuring and control. Often parents are very puzzled by their child's abnormal behaviour and hence worried and uncertain regarding what they should do. It is important that families be helped to gain an understanding of the child's problems but it is also necessary that they learn what to do, that is, that they be helped to gain effective problem-solving skills. Often, they have worries, anxieties and guilt that are, in part, irrational as well rational. Many parents of handicapped children worry at some time that they have played a part in causing their children's disability by what they did and did not do. The therapeutic approach must provide an opportunity to deal with such concerns if they are present. In addition, as I have indicated, it is likely that there will be many practical burdens on the family and ways must be sought to reduce them as far as possible.

Planning of Services

Finally, let me comment on some of the issues that need to be considered in relation to the overall planning of services to meet the needs of autistic individuals and their families. There is, of course, no one "right" pattern. The particular ways in which services are best organized will depend on the resources that are available and on a host of other factors such as geographical dispersion or concentration of the population. Nevertheless, there are several general considerations that require attention.

Let me begin with the need for good diagnostic services and on their availability for children when they are quite young (Rutter, 1985b). By diagnosis, obviously I do not mean just the giving of some appropriate label for the nature of the child's problem. Rather, what is meant is a systematic and thorough evaluation of the degree and pattern of the child's handicap and strengths; an assessment of possible contributory medical factors; an assessment of the factors that are influencing the child's behaviour at home and at school; the particular burdens faced by the individual family and a careful appraisal of the likely prognosis and other factors that may influence it. It is obvious that this is often going to involve professionals of a number of different disciplines such as, psychiatrists, pediatricians, psychologists and audiologists to mention but a few. If diagnostic appraisal and the planning of treatment is to work well, it is essential that there be a close coordination and integration between the disciplines. It is also important that it be clear who is taking the lead in providing ongoing care. It is not appropriate that treatment be run by a committee. Rather, one individual should be designated as the person to whom the family primarily turns to for advice. Other professionals may well be brought in for specific purposes but somebody needs to have an overview of the situation as a whole. I do not think that it is appropriate for any general recommendation to be made as to which discipline should be responsible for this role. In the

services with which I am involved, it may be someone from any of the disciplines that I have mentioned. What is really important, however, is that, whichever discipline it is, the person concerned appreciates just what they do not know, as well as what they do. In other words, it is crucial that they know when they need to turn to somebody else for advice or appraisal. I should add that, of course, as the needs change as children grow older, it may be appropriate that the key worker also change.

There is I think, a very important role for volunteers and assistants of different kinds. Naturally, this does not mean that it is acceptable for treatment to be provided by people who do not have the training and experience required to give what is best. However, it has been our experience as with that of many other people that volunteers can be extremely helpful if they receive appropriate training for the role they are to play. For example, many special schools and classes make use of teacher assistants; there is a role for volunteers too in the provision of both day and residential child care and especially in the range of services that may be provided through parents organisations of one kind or another.

The setting and the maintenance of high standards of care in services of all kinds is crucial but, also, quite difficult to achieve. It has been my experience that it is all too easy for individual units, however well intentioned, to drift in their standards and to slide into unsatisfactory forms of care if they remain too isolated from what is going on elsewhere. It is extremely helpful to have external advisors who can consult in schools and special units of all kinds in order to provide an independent assessment of what may be needed. I should make clear, of course, that it is equally important that those running services have the autonomy and independence to get on and do the job they need to do. It is not helpful if responsibility is diffused and left vague. Nevertheless, all of us benefit from discussion of problems with other people and from their suggestions.

The very last point that I wish to make concerns the need for professionals to take families into their confidence. It is important that parents be able to share in the decision making in the planning of what needs to be done in their child. If they are going to do this effectively, it is essential that they have the knowledge base to take the necessary decisions. Often, it is helpful for parents to have a written account of the assessments and recommendations made by professionals in relation to their child. It is all too easy in the stress of the clinic visit for families to misunderstand all that is being conveyed and having it in writing aids clarity of communication.

Conclusions

Let me conclude by noting some of the needs for the future and some of the possible developments in treatment and services. As is all too evident in what I have had to say, many challenges remain to be met. It is possible here to single out only a few of them. Behavioural and educational methods have the main place in the alleviation of handicaps; they are not curative, nor can they be expected to become so in the future. Medical advances in the years to come may bring with them the development of specific medical treatments. Thus, it is conceivable that findings in genetics, or in one of the other biological facets, may lead to more specific forms of intervention. Nevertheless, it has to be said that there are no specific treatments of this kind on the horizon at the moment.

One obvious need in the field of behavioural and educational methods is the devising of better techniques to aid social development. As I have indicated, techniques ideally should be based on what is known about the cognitive (or other) deficits that underly the social difficulties. If these are thought to derive from a lack of empathy or lack of a theory of mind, we need to ask what may be done to remedy or circumvent that lack? Secondly, methods facilitating social communication need to be improved. Up until recently, the main emphasis has been on spoken language but, as I have sought to emphasize, it is clear

that at least as much attention has to be paid to its social usage as to its complexity. Also, we need to determine how much can be achieved through the use of signing or other alternative modes of communication.

A third objective for the future must be the development of better ways of helping autistic adults. In some respects their needs are similar to those of children but in some respects they are different. Let me note just two differences. The transition from school to employment is very difficult for many autistic individuals. What can be done to aid the acquisition of work skills and of behaviour that is suitable for the work place? How many appropriate jobs be selected for autistic adults? A second concern is to work with the autistic individuals themselves to help them cope with social and sexual difficulties. Many of the more mildly handicapped persons become more self aware, an awareness that sometimes leads to unhappiness and concern over their difficulties. May counselling be of value in this connection and if so, what form should it take? To what extent may social skills training be helpful in an adult life?

Fourthly, can special talents that some autistic individuals possess (usually in memory, music, mathematics or accurate drawing to perspective) be put to effective use in treatment? The only other future need that I should mention is improved means of helping parents gain coping skills so that they can decide for themselves what to do with the next problem or crisis when it occurs. It remains unclear which elements in the therapeutic programme are most effective for that purpose as we do not, as yet, know how much can be achieved in aiding the acquisition of coping skills.

In conclusion, let me simply state that psychoeducational methods currently constitute the mainstay of treatment. They are not curative but they can bring about worthwhile gains. Already we know a good deal about which methods work best but crucial therapeutic challenges remain to be met in the future.

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自閉症的最新概念，研究資料及其對有關服務之影響

Michael M. Rutter

自 Leo Kanner 初次論及自閉症，至今已接近半個世紀。現時治理自閉症人士的方式跟四、五十年代的有明顯的分別。一些轉變固然來自過去臨牀經驗及研究的結果，但，主要的改進實有賴於我們對自閉症本質有更深的了解，從而認識那一些治理方法更爲有效。事實上，在釐訂個別治理計劃或整體服務模式時，是需要有一個以研究心得爲根據的基礎。研究的範圍應包括自閉症的發病原理、成因，其特有的心理問題、影響病情發展的可能因素及各種治理方法的成效。

自閉症——一種神經機能發展失常現象

就自閉症的性質，在不同的時間曾有不同的理解。起初，自閉症曾經被誤以爲是精神分裂症的雛型，即被視作一種兒童功能性精神病，現時已証實兩者代表甚爲不相同的症狀。其後，很多精神科醫生又認爲自閉症是由於受到父母敵視或疏於管教而產生「跟現實脫節」的心理病態，現時已知這觀點是錯誤的。理由是疏於照顧或虐兒所引起的社交及語言方面的異常有別於自閉症在這方面的問題。再者，不少研究顯示自閉症兒童是來自不同類型的家庭，其中有好的、壞的、冷漠的，與一般兒童的成長背景分別不大。

至於較新的觀點則認爲自閉症是一種由於神經機能發展失常而引致在思考及社交方面不足的現象。由於這觀點對治理模式的影響重大，我會列舉此類研究的幾個重要發現：

首先，本人及同工的研究顯示約有百分之二十五的自閉症人士在少年時期會患上癲癇症。該發現還有另外兩個研究支持。癲癇症尤其容易在自閉兼嚴重弱智之人士身上出現。不過，一般弱智人士通常在童年早期便會有癲癇症，而自閉症人士往往在少年甚至成人初期才開始有癲癇症。此乃首個顯示自閉症與腦部機能發生故障有關。

繼有關癲癇症之出現的研究，很多其他研究均紛紛對自閉症與官能異常的關係提供間接証據。例如，有研究發現，自閉症有時會與先天性痲疹及染色體異常等症狀同時出現，縱使這種情形爲數不多，仍然值得醫務人員額外謹慎，爲自閉症人士作徹底身體檢驗，以明白自閉症與其他病症的關係。

此外，約三分一自閉症人士的血液含有較高的血清素。這種現象亦有出現在弱智人士及某些神經系統病患者身上，故非自閉症人士所特有。然而，這項發現未能提供明確的証據，但它起碼支持自閉症可能與腦器官受損有關。

最後值得一提的是研究資料雖然顯示自閉症人士的腦部機能確有異常現象，但仍未能具體掌握異常的分佈，故對治理方面並沒有幫助。自去年開始，有人提出自閉症可能與一向負責控制平衡及肌肉協調的小腦異常有關。此論據尚有待証實，未能用以作治理計劃的基礎。然而，隨著腦科專門研究及測驗方法的迅速發展，日後定能提供更精確的指引。

有一點頗爲明確的是，雖然大部份的自閉症人士兼有不同程度的智能障礙，但自閉症跟弱智在下列幾方面均有顯著的分別。第一，剛才我已提過，若同時患有癲癇者，弱智人士初次產生癲癇是在較早期，但在自閉症人士中則較遲出現。第二，唐氏綜合症是弱智的一個最普遍的成因，但它跟自閉症絕少

扯上關係。同樣，大腦麻痺與認知損傷及弱智的關連很大，卻甚少與自閉症共存。所以，弱智與自閉症的來源，縱或有些少共通，基本是不相同的。此論點亦在腦掃描及有關神經系統異常的研究中獲得支持：嚴重弱智人士的大腦病態通常較爲大規模，自閉症的病態則比較微細，而且多限於小腦及基底神經節的部位。雖然，自閉症與弱智之不同的發現未能針對治理模式提供明確建議，但起碼會在醫療性的干預上起一些作用。

自閉症的遺傳

從病源學的角度看，自閉症深受遺傳因素所影響。然而，這方面一直不爲人注意；究其原因，有下列三點：(一)從數據顯示，若家庭內其中一名子女患有自閉症，其他弟妹同時患有自閉症的機會僅爲百分之二至三。這數字表面看似很低，但若以每一萬名人口僅有三名屬自閉症的比例比較，百分之三的遺傳機會其實已是很高。縱使以一個較廣泛的自閉症定義來統計，每一萬人也不過只有大概二十個病患者。換言之，弟妹可能患有自閉症的機會比常人高出十至一百倍。(二)自閉症人士甚少結婚及生育子女，故遺傳給下一代的機會往往是絕無僅有。(三)由於自閉症兒童對家庭帶來沈重的負擔，假若父母本身已經擁有至少一名正常孩子時，他們便不會再生育子女，這無疑大大減少了家庭內有多於一名自閉症孩子的機會。

爲了探討遺傳因素的影響，本人曾於七七及八九年與其他學者進行有關研究，結果顯示在同卵孖生的樣本中，若其中一名患有自閉症，另一名孩子患有自閉症的機會高達五成，而認知及社交方面發現有些異常者則高達九成。至於在異卵孖生的樣本中，少於一成在認知及社交方面失常。由此可見，自閉症的遺傳率非常高——可能達至九成以上。

我與同僚進行的家庭研究同樣發現遺傳的重要性。除百份之三的弟妹患有自閉症外，大概百份之十五被發現在認知方面有些失常，主要的毛病是語言發展延誤，這數字爲非自閉症家庭的出現率之三倍。同時，又有百份之十五有類似自閉症所特有的社交障礙，而在非自閉症家庭的弟妹却沒有發現這種障礙。家庭研究與孖生兒童的研究結果相應顯示，自閉症的遺傳不單限於自閉症的傳統症狀，還涉及認知(特別是語言方面)及社交(特別是互惠能力方面)的失常。此類障礙通常發生於智力正常的自閉症人士，間中亦有在兼有弱智的人士中出現。綜合而言，自閉症的特色不在於弱智，而在於其在溝通及人際關係上的異常，故此，治療的方針應在這方面加以考慮。

自閉症——一種神經心理失常現象

第三個角度是將自閉症看成一種神經心理失常現象。以下提出三大要點。首先，研究顯示自閉症的認知障礙有其獨特真實的地位，並非由其他障礙引起。以前有人認爲自閉症的認知障礙是他們的離羣性格所引致的，現在已證實爲誤。智商的應用對自閉症人士和對普通人一樣，可以預測他們的學習表現及日後適應社會的能力。智商實爲自閉症的最佳預斷指標。

第二要點指出自閉症的認知障礙形態與弱智的截然不同。自閉症人士的異常較多涉及與語言有關的能力，尤其在序列，抽象性思考及象徵性理解等能力上見不足。

第三，過去幾年的研究指出自閉症人士有獨特的社交認知障礙，可能影響他們的人際關係。這些障礙可分爲兩類：(一)未能分辨及掌握社交及情緒方面之提示；(二)未能使用社交及情緒的訊號。研究顯示自閉症人士在揣摩他人內心的思想及觀點上遇上很大的困難。比方在其中一個實驗中，有人趁另一人離開房間後收起一件物件，多數孩童會理解到當那人回來時，他會往物件安放的原位找尋而不會往收藏處看，因爲他曾離開房間，根本不知道物件被人收起，更不可能知道它藏在何處，但自閉症兒童却完全不會理解到這一點。這可謂是缺乏一種「分析人思維」(Theory of mind)的能力。

很多有關神經心理失常如何影響社交行爲的問題尚有待解答。至今我們仍然未清楚這種失常的獨特程度及上述兩類的障礙之間的關連。無論如何，我們一定要預計自閉症人士在掌握社交提示及明白別人內心思考方面有一定的困難。雖然治療究竟可以影響這些障礙的發展有多少仍是未知之數，在計劃如何改善自閉症人士的社交行爲時，我們仍需照顧這方面的需要。

自閉症病情預測(Prognosis)

就自閉症人士的病情發展，不同的研究結果都大致吻合。這些研究有下列發現：

(一) 若然斷症準確而又在三歲以後進行，被斷爲患有自閉症的人士一般很難完全復原。即或是有些非語文智力正常，他們長大後仍會在社交及與人溝通方面出現或許細微但頗明顯的問題。例如，在我跟進六十位有正常非語文智力的人士中，他們成長後，只有一人已婚而幾乎沒有其他人與人有過性關係。

(二) 然而，成人的自閉症人士會較想與人建立社交關係，但由於本身的缺陷，往往力有所不逮，因而產生不少挫敗感，故此特別需要專業人士的協助。

(三) 不論有否接受治療，自閉症人士過別的復原結果差距極大。有些需要完全依賴別人照顧起居，但有部份却可以自力更生及獨立生活，當然其中有些只可在庇護環境內工作或自立。值得注意的是，有些自閉症人士縱使沒有經過任何治療，仍然可以有很大的進步。

(四) 自閉症人士日後的發展情況基本上可按他在接近入學時的認知及語言能力作出預測。那些非語文智商低於五十而在五歲時仍未有自發的語言的，一般表現較差。相反的，那些非語文智商在七十以上而在五歲時已能與人溝通的表現最佳。

(五) 直到目前爲止，病情好壞與自閉症小孩的家庭背境及社會環境無關。但從觀察所得，若然父母不辭勞苦，竭盡所能爲孩子尋找服務及輔助他們成長，孩子日後的發展通常是最好的。

(六) 自閉症(尤其是輕度的)人士直到成年早期，仍然可以有進步。在我們的長期研究中，有不少過案在剛離開學校時仍缺乏工作能力，却在二十幾歲時，找到工作並維持半獨立的生活。

(七) 患有自閉症的成年人很多時連帶有精神問題。有些可能因社交有困難及身受挫敗感引起抑鬱；有些抑鬱病可能是內生的，另外更有些患有執著强迫症和慣性抽搐症等。訂立治理計劃時便需顧及這些問題。

治療自閉症的方法及成效

在討論自閉症治理的兩大主流——行爲治療及教育方法前，讓我先約略談談某一些聲稱對自閉症有獨特療效的治理方法。

(一) 醫學方面：這些包括使用維他命，營養控制及服用 Fenfluramine 藥物。

甲) 維他命：主要的治療是服用鎂及維他命 B6。曾經有數個研究報稱對某些兒童有顯著雖然不算大的效用。但證據顯示其效用並非如此神奇。甚至所見之效果是否與服用維他命有關也值得相榷。事實上以維他命治療自閉症並無清楚理論基礎，不過是基於一個普及的信念，認爲服用大量維他命對某些疾病有幫助。我個人的意見是：幫助太少及不明確，加上大量服用可能有危險，故不值得推薦。

乙) 營養控制：是透過在進食習慣中，減去各種食物的附加劑，以改善自閉行爲。同樣，未有足夠証據證明此種方法有明顯成效。或許會有少數兒童不適應某些食物內的原素，有

敏感反應因而導致坐立不安及專注力差。但要求一個普通的小孩依循一個非常嚴格的營養單進食已經是很困難，更莫論自閉症的兒童。所以我也不支持此方法。若有家長留意到他的小孩飲用某些食物後的行爲表現有惡化，或者可以酌量減少該類食物。這提議是基於常理，只要小孩的飲食能保持均衡，減吃一些食物也無傷大雅，又或許有些少好處。不過，家長不應存厚望，以爲這種做法會對自閉症的基本缺乏有任何實在的幫助。

丙）Fenfluramine：這種藥物主要用於壓抑食慾以減少血液內的血清素。我在上面已提過，大概有三份一的自閉症兒童的血清素水平頗高。這種方法曾一度備受推崇，但現在已有大量研究資料証明這藥物對大多數自閉症兒童起不到作用，而間中極少數量所得到的反應亦未能影響自閉症的基本缺陷。還有，該藥物的任何成效均與血清素的水平無關。最後，該藥物被發現對動物有毒性，現在用在人身上，未知會否有潛在的毒性，既然幫助不大而有可能有害，我也不會推薦這藥物。

（二）心理方面：兩個聲稱頗有成效的治療方法包括由 Lovaas 運用非常緊密的操作性制約原理（Operant Conditioning）制訂的方法及摟抱治療（Holding Therapy）。

甲）操作性制約法：根據 Lovaas 一九八七年發表的研究結果，在十九位接受治療的兒童中，近五成能夠達到近乎正常的智力、語言及學習能力，並在他們當中不再發現有永久性的智力及行爲缺陷。相對來說，在其研究的對照組中。只有百份之二達到上述的表現。這個近半數的復原率似乎與世界公認的現象——即自閉症兒童絕少能完全復原——大相逕庭。此外，該研究在設計及方法有不少缺點，雖然不能因而完全推翻其報稱的成效，但其可信性則受質疑。例如，其研究之孩童平均接受評估的年齡爲三十二個月，故可能有錯誤診斷之虞，加上缺乏跟進測驗，未能知道長遠的效用，其驚人的好結果可能是由此而形成。我們對 Lovaas 的研究抱懷疑態度，主要是因其結果太戲劇化，並且與大多數研究完全不吻合。直至他的結果能有其他獨立的研究印証，我們難免對他的治療方法有所保留。

乙）摟抱治療（Holding Therapy）：Tinbergens 在他的著作中大力推崇「摟抱治療」。方法是把兒童緊抱表達一個半少時之久，目的是挑起其憤怒，繼而克制它。直至目前，此方法還未有足夠研究支持其報稱之效用。當兒童的情緒激動時，成人緊抱著他們，可以作爲一種安慰幫助他們平靜下來，這一點實無可厚非。引起爭論的是他們認爲爲了要製造機會緊抱兒童便可以故意激起他們發怒，這種做法的理論基礎令人費解，而且與我們一般處理孩童的方法相違，所以我不喜歡推薦這個方法。

現在讓我與大家分享比較常用的行爲治療及教育合併法的效用及證據。現代行爲治療及教育合併法

（一）根據本人與同工在七三年的研究資料顯示，自閉症兒童若能在一個有規範的課室中接受大量緊密而專門的訓練，他們的學習及行爲進展會較佳。反之，若職員不積極作行爲規範，容許兒童自訂節奏隨意學習，他們的進展會最差。因些，我們爲自閉症兒童提供的訓練是需要有系統、有組織及針對個別兒童的需要而編訂。雖然不能完全克服自閉症兒童的基本障礙，同時個別的反應亦有很大差距，但其效果堪稱滿意，值得採用。

（二）研究資料亦顯示，針對兒童行爲問題的密集家居訓練較傳統的門診治療有效。換言之，訓練會令兒童有明顯的改進，而行爲學派的方法尤爲有效。不過，值得留意的是，最大效益見於與自閉症無直接關係的一般行爲問題，例如恐懼、發脾氣、粗暴行爲及遺尿。最少效益見於智商及語言運用的改進，就語言而言，只限於改善在社交方面之運用，而無助於整體的語言發展。另外要強調的是，治療往往在短期內帶來顯著的改變，然後改進隨著時間會放緩。

（三）訓練的效果其實亦因人而異。縱使治療師及家長費盡心血，最弱智的兒童的進展往往是最少。特別是有弱智而在學齡時仍未有發音及明白語言的能力，甚或不懂得參與想象性遊戲的兒童，他們的前景較差。最好的訓練也祇能減少他們的騷擾性行爲及改善他們的社交技巧，但不能使他們懂得運用語言及照顧自己。相反的，非語文智商正常及能掌握語言技巧的兒童則前景特別好。值得一提是，最優秀的自閉症兒童，就算沒有接受治療也會有良好進展，不過，加上家居行爲訓練，他們會表現更好。

（四）有關家長對此類訓練的意見，有人做了一個獨立研究，發現家長認爲效益好，值得參與，更証明這類方法的價值。然而，有時效果未必持久，家長很多時在訓練課程完結後，不懂得運用以前所學的去處理兒童的一些新問題，故似乎有需要在課程完結後繼續爲家長提供有限度的專業輔導服務。

（五）透過一連串組內比較及個案研究，我們發現訓練成效與訓練方法確有直接及系統性的關連。尤其重要的發現是，兒童的得益與家長能否靈巧地循正軌教導兒童的靈巧程度成正比。

行爲治療及教育合併法的原則及要素

以下討論涉及構成一個有效而全面的治理計劃的要素。

（一）治理方法：

甲）有效的訓練並不限於某一技巧或一套特定的原則，而是會廣泛地採用各種以學習理論爲基礎的技巧和方法。其中的遞減式改變(graded change)對處理異常的固執行徑、偏念及依附性行爲尤爲有效。其原理在於按步就班地在兒童可容忍的程度下一步一步地協助他們變更一貫行爲，假以時日，積聚的改變便相當可觀。另一治理方向是教導兒童有效地應付一些本來會使他們感到沮喪或使學習有障礙的情況。環境控制亦能助兒童避過一些困難的景況。强化技巧，不用說可以鼓勵好行爲及終止不良行爲。

乙）有效的訓練必需從準確的診斷評估開始。我們需要了解兒童的强處、弱點、非語言及語言的發展進度，甚麼環境會影響他的行爲，及他對不同情況反應。換言之，一個精密的心理評估是治理計劃不可缺少的一部份。評估其中一重要的步驟是對可能影響不良行爲的環境因素作一個全面的觀察及分析，以求了解甚麼情況會引起維持增加或減少某些不適應的行爲。

丙）有效的治理一定要先了解兒童在他自然環境內的行爲表現。有研究指出要把效益從一個環境推廣至另一環境是成功治療的最大挑戰。換言之，住院治理實在有相當限制。所以，情況許可下，應盡量在社區內與家長一齊合作教導兒童。

丁）無疑，邀請家長作輔助治療是上策，因爲他們經常接觸兒童，最清楚了解他們在不同情況的反應及甚麼方法最合用或不合用。

（二）學校選擇：這是整個治理計劃的重要環節。我們不能止於把兒童放進特殊教育學校，更要考慮每個兒童的特質，安排切合他們的課程。我們理解到特殊學校也可以在課程上有不同的强調及取向，所以一定要爲兒童配對最適合他們的教育形或。

（三）輔助性服務：治理計劃不應限於訓練，更要確保自閉症兒童在各方面得到協助。例如：輔導有自閉症的家庭渡過困難，遺傳知識輔導或其他有需要的醫療服務。

（四）藥物治療：自閉症本身並無特效藥。但有時兒童情緒上有極端的反應或呈現過度活躍行爲，又或有其他騷擾性行爲，藥物在這些情況下會有一定的幫助。不過，我本身的經驗是，青年人及成年人比兒童較需要藥物的輔助。興奮劑(例：Vitalin)似乎對自閉症的過度活躍行爲療

效不大，甚至有研究指出它們可能增加刻板動作，甚至引起焦慮及思維動作遲鈍。間中，興奮劑對正常智力的自閉症兒童有幫助。毒性較弱的 Thioradiazine 似乎最合用，可以稍爲減少一些不適當的情緒反應，以便使兒童的反應減至社會可以容納的情度。留意有些自閉症的兒童對這類藥敏感，所以只宜用少量。另一有效益的藥是 Haloperidol，可以控制暴擾性行爲及自動化肌肉抽搐，不過它可能產生副作用，特別容易引起肌肉聚縮失能。

（五）溝通訓練：治理自閉症的首要目的是促他們盡量接近正常發展，其中當然包括認知、語言及社交的發展。過去的行爲訓練往往著重鼓勵兒童用言語表達，最近則强調能在社交時講出說話，而社交發展最宜在一個愉快而又鼓勵性的氣氛內培育。然而，自閉症兒童偏偏對社交訊息的反應遲鈍，故此，治療的焦點應放在提供更多有規劃性的與人接觸機會。如是者，我們應該盡量避免在早期讓兒童入住宿舍。同時我們可以直接傳授社交技巧，可惜在這方面的研究非常缺乏。最近更有些研究提議多利用同輩接觸交流作訓練，究竟怎樣形式的教導最有幫助，現時仍未清楚。我提議治理的未來動向應多考慮自閉症兒童在了解他們的社交環境面臨的困難，並且多提供合用的社交技巧訓練。

（六）家庭輔導：我認爲另一治療目標應該是幫助家庭面對他們的困境。有一個自閉症的兒童在家裡，父母及其兄弟姊妹必然面對很多的心理負擔及挫敗感，尤其因爲自閉症兒童對外界事物不感興趣，沒有反應及需要很多精力照顧及控制，至爲重要的是協助家人清楚明白兒童的病情及教導他們如何應付難題。有時他們有很多憂慮，需要向人傾訴，有些甚至會自疚，感到自己要爲小孩患上自閉症負責，保持一個輔導的關係可以給予他們機會處理內心的疑慮。

服務的策劃

最後，我會對如何全面性策劃爲自閉症人士而設的服務提出八項意見。很明顯的，沒有一個模式會是絕對完善的。服務的編排需要視乎當地的資源、地理環境及人口的分佈而定。一般而言，有下列幾點需要注意：

（一）優良的早期評估服務：所謂評估，當然不是指給予兒童的問題一個病名，而是一個徹底而有系統的檢討，找出自童的障礙與長處、生理上可能有的問題、能影響兒童在家或學校行爲的各種因素、家庭面對的困難及心理負擔、與及審慎地研究個別病情發展及可能影響發展的因素。這方面的工作顯然需要各種不同專業人士的合作及聯繫。

（二）專業間的合作和聯繫：在每個個案中，都應該有一位專業人士負責統籌及領導角色，以便掌握整個個案的發展及方便有關家庭尋求專業人士的意見。至於那一個專業應負起這個統籌的角色，我不宜發表意見。其實任何專業人士也可以負責，只需這個人能明白自己的專長及局限，懂得在適當時候邀請其他人提供意見或作評估。這個統籌的人員亦可能隨着兒童成長需要不同而更換。

（三）義工參與：義工祇要經過適當的訓練，往往能協助專業人士提供實貴的服務，特別在託兒所或由家長組織所提供的服務，義工可以扮演一個重要的角色。

（四）專業顧問：經常維持高水平的服務質素並不容易，在缺乏新知識及外界的衝擊時尤其困難。若能有外來的專業顧問定期到學校或特殊訓練單位提供客觀與獨立的意見，及共同討論，工作人員一定得益不少。不過，這並不代表責任分卸或制度架空，每項服務宜保留一定程度的自主及獨立行政。

（五）家長參與：在訂立個別治理計劃時，家長的參與也很重要。若要家長有效地參與，他們必須對自閉症有一定程度的認識。一份有關孩子的評估及建議報告交在家長的手，會對他們很有幫助，特別因爲在診所時，家長往往不能全然接收專業人士的講解，文字記錄更能達溝通之效。

結論

讓我嘗試總結治理方法及服務未來的需要及前景。以上的討論明顯指出我們仍面臨很多的挑戰，我在此列舉一二。首先，我要強調行爲治療及教育治理模式是當前最通行的方法，但他們現時甚至將來都不可能根治自閉症。或許隨著醫學研究的進步，我們可能從遺傳學或其他生理方面的研究找出一些對症下藥的醫學新方法。不過，再一次提醒大家目前還未有此類獨備方法。

其次，在行爲及教育治理的範疇內，我們需要發掘更好的技巧協助自閉症兒童的社交發展。最理想的是能根據社交障礙背後的認知問題而制訂方法。假如問題出於自閉症人士缺乏分析別人思維的能力，我們便要考慮如何補救或防止它惡化。還有，教導自閉症人士在社交場合與人溝通的方法仍有待改善。直至最近，訓練一向側重口語的運用。我一再強調，我們不單鼓勵多元化的語言理解，更要同時注意其在社交時有效的運用，同時，我們亦應探討用手語或其他溝通媒介的可行性。

第三個目標應該是發展更多協助成長了的自閉症者的服務。他們有些需要是有別於自閉症兒童的。例如由學校轉往就業階段的適應，很多自閉症成人需要學習一些基本工作技巧及在工作環境如何與人接觸，此外，他們在社交及兩性方面的困難，可以帶來很多痛苦，輔導是否可以幫助他們？若是的話，何等服務最適合？還有，一般社交訓練是否對自閉症成人有幫助？

第四，我們亦可以考慮如何利用自閉症人士的特殊能力，例如音樂、數學、記憶及繪圖之天份作有效的訓練。

THE MANAGEMENT OF AUTISM IN HONG KONG — CHALLENGES AND DIRECTIONS

C.K. Wong

Introduction

There has been an increasing awareness of the problem of autism in Hong Kong, both among professionals and lay people. As a result, demands for services have increased which at least have been partially matched by an increase in provision of services. However, in the scenario of trying to provide more and better services, a number of important gaps have become even more obvious. I will try to point out some of these more important gaps:

(1) Where Have All The More Intelligent Autistic Children Gone?

Statistics show that about 20 to 30% of autistic children have a non-verbal I.Q. above 70 which puts them in the normal range. But so far all the services are heavily biased towards the subnormal group. In our clinical practice, just over the last few years we have identified a large number of autistic children of better intelligence. Many are referred from schools and the Education Department as suspected cases of conduct disorders or "madness" of various sorts. Many are already in their adolescence, having bewildered and saddened their parents and teachers throughout the years.

(2) Who Looks After The Parents?

The services have another strong bias and which is towards the autistic child with relatively much less attention given to the parents. In our clinical practice, with very few exceptions the parents of autistic children who come under our care have had received very little psychological support. As part of our routine work, we find it of tremendous importance to explore and resolve emotions such as guilt and shame. This together with a consistent psychological support often results in the successful mobilization of parents in training programmes.

(3) Parents Are Not Involved As Much As They Should

Most schools or special child care centres do involve parents and may even have parents' groups. But it seems that the majority of parents are still rather detached from the services. This is obviously related to (2) and also has to do with rapport between the services.

(4) The Homes Are Untouched

Most, if not all, services for autistic children are centre-based rather home-based. This is understandable from the point of view of limited resources. However, the advantages of home-based programmes are so obvious that bridging the gap between the centre and the home should be given a high priority as well. This is an area where trained volunteers may be of great help.

(5) Specific Deficiencies in Services

First, it is true that in general the staff-patient ratios for all the professional disciplines concerned are inferior to those recommended or practised by other developed countries. Second, for some specific disciplines such as speech therapy the services provided are very meagre indeed.

(6) Services Are Not Integrated Sufficiently

This is true cross-sectionally and also longitudinally. Cross-sectionally, geographical and professional boundaries are still in many instances clearly hindering. A genuine multi-disciplinary approach will allow resources to be used more fruitfully, economically and thoroughly. Even more importantly, there are serious gaps in the longitudinal coordination of services, from infancy to pre-school, from preschool to school, and from school to adult services. Very tangibly these gaps mean waiting for a few months to a few years before a suitable placement in the next stage is available.

Conclusion

To conclude, these gaps are becoming more obvious as more autistic children are being identified and demands for services are increasing. Filling these gaps, both clinically and administratively, should be regarded as matters of urgency. These are the challenges and directions of services for autistic people in Hong Kong.

自閉症兒童家長經驗分享

馮楊麗珍

當我發覺我的兒子是有自閉症的時候，一時之間感到晴天霹靂，連行路都腳步浮浮，好像自己患上絕症一樣，瞬間不能接受這個事實。

有很多人說，我的兒子外表看來和其他孩子一樣醒目和可愛，怎料他是個弱智和自閉症的兒童。一時之間感到徬徨無助，又無人開解自己和提供有關自閉症兒童的正確資料，我開始感到焦慮、恐懼。

此外，我又受到其他人誤解及歧視，例如鄰居說自閉症兒童有精神病及會打人、行為怪異等。當我受到別人的冷落和指責時，實在是很難受。

我在街市賣菜，生意好些，別人就說：「抵你死！生了一個自閉症的兒子。希望你十世、二十世都是生個自閉兒子。」我再一次感到難受。

現在，我已接受了事實，自閉症的兒童外表雖然和平常人無異，但行為和智力大有問題，視乎深淺程度。在我兒子二歲時，我發覺他行為有怪異，喜歡重覆做一些無聊的動作，例如咚咚轉、自己打自己的頭、踢汽水罐、玩煙包等，對玩具沒有興趣。當我叫他的名字，他沒有反應；兼且非常活躍，在家中不停走來走去，爬高爬低，亂掃什物和家具。想休息一會根本沒可能。語言方面更差，三歲半之前簡直沒有語言。

身為一個自閉症的兒童的家長，要面對的壓力實在很大。照顧及教導自閉症兒童很困身，例如去得遠不想帶他去，但去得近，又不放心留他在家中。但最頭痛的是兒子大小便隨處撒，要花很多精神和時間照顧他。夫婦常因教導子女而發生爭執，真的有點意志消沉。

大約等了一年左右，當兒子入了協康特殊幼兒中心後，我們較為輕鬆一點，接受了適當的訓練和在導師的悉心指導下，我學會教導孩子的正確方法。每天工餘時間，積極地教導及訓練他。最初他只講一些單音或雙音，但行為方面已有不少改善。現在更能表達到自己意思，例如：「我要食麵包」。並能聽我指示及自己上廁所。我感到一份莫大的鼓勵，更加感謝協康會幫助。

所以，我覺得自閉症的兒童越早得到訓練越好，但社會給予自閉症兒童的學前學位不足，這包括了特殊幼兒中心及混合幼兒中心。很多家長在入中心之前對有關服務並無認識，例如無人介紹可以參加早期訓練計劃。另外，很多學前訓練機構不肯收自閉症兒童。因此很多不幸的兒童，在早期得不到適當的訓練。

另一方面我也擔心兒童將來很難適應社會，對他的特殊行為憂心，怕社會、大家不接受他。擔心他謀生及自我照料的問題，因為很多自閉症人士都不懂和別人溝通，他們的年紀越大，要擔心的事便越多。

我曾經和很多自閉症的家長傾談過，大多數都擔心他們的孩子接受完學前教育後，不能及時入讀特殊小學，以致在家裏得不到訓練，便會慢慢退步，那時情況就更慘了。

特殊小學的學位不足，以及學校不願收自閉症兒童的事確是存在。有學校校長提及，校方有自己的難題：政府資助少、缺乏支持學校提供自閉症教育的計劃及實質支持，例如資助及多增學額，多請資源老師助教等。

所以本人和所有家長都很希望政府有關部門及教育界人士能正視這一個問題，做一些實際的行動，例如政府可撥多些師資和經費給予特殊學校，而特殊學校也可撥多些學位給自閉症的學生，解決這一方面的困難。

最後，我想要講的就是：我的兒子雖然有自閉症，但我仍會積極地全心全意教導及愛護他，希望社會各界人士也能接受他們需要教育。

SUGGESTIONS FOR DEVELOPING SERVICES FOR AUTISTIC PERSONS

Wan Sing-hin

The Syndrome of autism is a seriously incapacitating disorder characterized by multiple deficits in areas of communication skills, social relationship, behavioural response and normal functional skills. In order to help the autistic individuals to live a normal life, to learn to be independent and to develop their full potential, a variety of services are needed for them.

Due to the limited services available for the autistic persons, in 1982, our society 'The Society for The Welfare of Autistic Persons' was formed by a group of concerned individuals and parents of autistic persons with the aims of fighting welfare and developing appropriate services for these persons. At present, our society has about 270 registered members, but many of the autistic persons are still lacking appropriate services.

Existing Services Available for The Autistic Persons

In recent years, there is a great advance in the development of pre-school services for the autistic children. These services include Diagnostic and Assessment services in hospitals and clinics; Early Education and Training Services; Special Child Care Services; and Services on Integrated Nursery and Integrated Kindergarten.

Undoubtedly, these services have made a significant contribution to the autistic children in their early year and also alleviated the burden and stress of the parents. However, as autistic persons are grouped under the category of Mental retardation, there is only limited provision of these services for the autistic children, and many of them have to be put on the waiting-list.

Furthermore, in many of the services mentioned, the parents are not actively involved in training their autistic children. It has been pointed out that the need to engage parents as co-therapists is important because the parents are the people with the most extensive engagement with the child over the greatest number of situations. (Howlin & Rutter, 1987).

As the autistic children reach the age of 6, they have to attend special schools. It was encouraging that in 1985 special provision for autistic children began to operate in special school. However, the places for them are still very limited. Many of the autistic children have to wait for one or two years even though they have finished their preschool training programmes.

When the autistic adolescents have finished their special educational programmes, they have to leave the school at around 16 years old. The only services that seem to be available to them are Sheltered Workshops, Activity Centres, Vocational Training Centres and Residential homes. However, these services are usually of limited places and have not taken into the special needs and conditions of the autistic adolescents. Many of them may simply stay at home, and some may end up in psychiatric hospitals!

As seen from above, the continuity of services provided for autistic persons needs careful re-evaluation.

Suggestions for Developing Services for Autistic Persons

What kind of services do autistic persons need? The list of possibilities is extensive. However, not all autistic persons or their family need the same type of help. The followings are some services that may help the autistic persons to become more independent and achieve full potential or to alleviate the family from burden or stress:

1. ***Information and Referral Services***

These services help to locate and gain access to the appropriate and needed services.

2. ***Transitional Services for Those Waiting for Integrated Nursery/Kindergarten***

These services aim at preparing the autistic children for schooling, and at relieving parents of stress and anxiety through educational and training programmes so that they have better understanding of autistic children and the appropriate teaching techniques.

Transitional Services for Those Waiting for Special Schools

These services aim at maintaining the self-care and the academic skills learnt previously. This may extend the services of integrated nursery/kindergarten with less intensive training.

3. ***Extended Special School Programme to Maintain Continuity and Structure for the Child***

These services try to prevent deterioration of functional, prevocational and self-care skills of the autistic persons while they are waiting for other services like sheltered workshop, activity centre.....etc.

4. ***Special Provision for Autistic Persons in Sheltered Workshop***

Many of the autistic persons can work in existing sheltered workshops for mentally retarded persons only if their special problems and talents are understood and explored by staff with experience in handing autistic persons. The service is just like the practice in special school.

5. ***Respite Care***

Respite care is needed to give parents regular time to relax. Day care centres should be developed to provide respite care, permitting parents to spend a weekend together or to take a vacation from the care of their child. The recruitment of volunteers with some training may be of great help in providing such service. Besides, training of babysitters who could take care of the autistic persons at their own home would be desirable as well.

6. ***Day Activities Centres***

Day activities centres are needed to maintain functional abilities of those less handicapped autistic adolescents after leaving special school.

7. ***Residential Services***

Residential Services should be available for autistic adolescents and adults. Since few autistic adults are capable of independent living, and most parents may find it extremely difficult to take care of their severely handicapped autistic adults at home. Residential schools and homes are the examples.

Conclusion

The needs of autistic children change as they grow older. There are also huge individual differences in response to treatment or training services. Therefore, it is necessary to consider carefully in planning the services for autistic persons. Not only it is important to coordinate and integrate various disciplines for better services, it is also necessary to have a good co-operation among various associations and authorities for the continuity of services provided.

Although our society is subject to the constraints of finance and manpower, we still try our effort, with the assistance from volunteers, in providing a variety of services which include seminars, educational talks, toy library, information services, recreational activities and respite care. We hope, with more support from the community and the co-operation with different associations, the welfare of the autistic persons can be protected.

訓練自閉症兒童的經驗分享

葉麗賢

背景

鑑於學前期的自閉症兒童有其獨特需要，與及該類復康服務之不足，早於一九八四年，明愛屬下的復康服務和家庭服務已開始合作，試辦一個專為自閉症兒童而設的治療小組。目前，本計劃為一非牟利服務，經費來源有賴外界贊助。

目標

本計劃是一個綜合性服務，以較為全面的方式去照顧自閉症兒童及其家庭的需要。所抱的目標是：

(一) 儘早減輕兒童的自閉特徵，加強社交、溝通、認知、自理、動作等方面的發展。

(二) 幫助家長去訓練自閉症兒童。

(三) 給予自閉症兒童的家庭適當輔導和支持。

工作人員

由不同的專業人士——包括臨牀心理學家、社會工作者、職業治療師、特殊幼兒工作員和福利工作員，提供各種專業意見。

服務對象

六歲以下，被診斷為自閉症或有自閉症傾向的兒童及其家庭；參加者並未有接受其他同類型的小組服務。

轉介來源

主要由復康服務及家庭服務轉介，亦有其他機構同工轉介。

計劃內容

(一) 治療小組——每週一小時，在兩個中心內舉行，每組十人。採用半組織形式，每次均有結構緊密的項目去訓練兒童的進展，如：安排全組或二人齊合作的遊戲；亦有兒童自由時間以觀察兒童在低規範之下的行為表現。項目包括訓練社交規矩及自理、對叫喚及指示的反應、大肌肉活動、小肌肉遊戲、羣體合作遊戲等。治療的基本原則沿用行為改造法，組後採用了一個客觀的行為評分表來檢討每次各兒童的表現，再綜合起來，從多方面去評估兒童入組後的進度。評估主要分五大方面：(一)與人關係、(二)溝通、(三)聲音及語言接收、(四)研究及操作週圍事物的動機和興趣、(五)對社羣的反應。

（二）個別訓練——每週一次，針對兒童的個別差異和需要。

（三）家長輔導——指導家長訓練兒童方法，幫助家庭成員去減輕兒童所帶來的問題，給予家長情感上的支持；有需要時，並作家訪。

（四）家長會議——每六星期舉行一次。內容包括講座，討論訓練技巧及照顧兒童知識；亦給予家長一個互相切磋支持的機會。最近並嘗試策劃家長自助小組。俾能充份利用家長之間的互助資源。

（五）週年個案檢討會議——邀請有關家長出席討論兒童進展。

（六）户外活動——歡迎家庭成員參加，提供兒童與外界接觸的機會，介紹家長認識社區資源。

（七）心理評估——定期評估兒童在智能方面的發展，並對兒童入學作出適當的推介。

（八）玩具圖書館——家長可借用玩具，以輔助訓練兒童。

訓練自閉症兒童的經驗分享

施美鳳
譚麗娟

自閉症兒童進入中心的程序

普遍來說，自閉症兒童多由醫生或母嬰健康院轉介到兒童體能及智能評估中心進行詳細的評估，再由社會福利署的學前中央轉介系統轉介到協康會屬下的早期教育及訓練中心或特殊幼兒中心。經過中心職員的約見，了解兒童的情況後，就會安排兒童進入中心。

特殊幼兒中心每日的生活程序

兒童進入中心後，就會按照中心的每日程序來接受訓練。

時間	程序
上午	• 玩玩具/自閉症兒童活動小組 • 早餐 • 早會 • 小組學習 例如：大肌肉活動 語文 勞美 音樂等課堂。
中午	• 午餐
下午	• 午睡 • 輕鬆課堂 例如：戶外活動 小食嚐試等。 • 下午茶 • 放學

自閉症兒童的問題

影響自閉症兒童學習的主要問題包括：

1. 自我中心，完全不在意身邊的人和事，祇陶醉於自我的世界。
2. 缺乏想像力及遊戲技巧，不懂變通，不會把所學的技巧遷移至日常生活中運用。
3. 專注力短，缺乏耐性。
4. 缺乏社交能力，經常逃避目光接觸，不會主動與人交往，有些兒童更會抗拒社交式的身體接觸。

5. 缺乏溝通能力，在語言理解或表達方面都有顯著的困難。
6. 不懂適當地表達情緒，常會無故發脾氣。
7. 性格固執，抗拒新事物，不易接受環境的轉變。
8. 過度活躍，不能安坐來學習。
9. 有自我刺激的行爲或重覆無意識的動作。

訓練自閉症兒童的目標

1. 提高專注力及安坐耐力。
2. 利用小心選擇的活動來提高適應能力。
3. 利用感知刺激，促進對身體的認知及提高對環境的注意。
4. 擴闊生活經驗，增强變通能力。
5. 鼓勵適當地表達情緒，減少無故發脾氣。
6. 提高基本社交能力，鼓勵目光接觸。
7. 訓練用手勢或語言來表達需要。

訓練的形式

1. 小組單元訓練
2. 個別訓練
3. 職業治療式言語治療
4. 活動小組
5. 家居訓練

除了以上不同形式的訓練外，中心職員亦會在日常生活中給予兒童機會練習所學會的技巧，同時幫助他們將這些技巧遷移至不同的環境中運用。最終目的是希望提高自閉症兒童在社交、自我照顧、遊戲及學習各方面的適應能力。

由於自閉症兒童都有一個共同點，就是他們都缺乏社交及溝通的能力，小組訓練的好處就是能夠增加他們的羣體學習經驗，從而提高社交能力。此外，這些兒童都較爲自我中心及缺乏專注力，以致未能自發地學習，故此，有計劃及組織的訓練程序便更能迎合他們的需要。加上自閉症兒童在學習時都需要較多提示及鼓勵，利用活動小組作訓練可以方便中心在特定的時間內安排足夠的人手入組協助，從而提高兒童的學習進度。

活動小組的運作過程

進行自閉症兒童活動小組前，中心職員會先甄選適合的兒童，當選擇了合適的兒童後，便會爲他們進行個別評估，從而確定他們的問題及學習需要，接着就開始計劃小組。

計劃小組的第一步就是訂立目標，然後針對目標來設計小組內容，此外，還要決定人數、時間、次數及人手比例等。在小組進行了一段時間後，就會作出檢討，檢討範圍包括：

（1） 兒童的表現及進度
（2） 小組的內容及程序
（3） 家長的參與情況

透過檢討以及再度評估，中心職員便會對小組的內容作出適當的修改。

活動小組的內容概略

小組內容大致可以分爲兩個主要部份，分別是常規程序及訓練活動。

常規程序就是小組開始及結束時的學習程序，例如，小組開始時，訓練兒童拖手排隊、叫名坐好或點名舉手等等，而結束時則訓練兒童分享、茶點揮手再見等。

至於訓練活動就是針對自閉症兒童的問題而設計的訓練，內容包括：

（1）感知肌能訓練 ——著重給予兒童不同的感覺經驗，以及訓練他們作出適當的動作反應。
（2）身體意識及認知訓練 ——提高兒童對身體不同部份的注意及認識。
（3）專注力訓練 ——透過有趣的活動及玩具來吸引兒童的注意，然後逐漸延長他們對事物的專注力。
（4）玩玩具技巧訓練 ——除了教導兒童有意識地玩玩具外，亦會透過分享玩具來鼓勵兒童之間的社交接觸。
（5）基本社交技巧訓練 ——透過活動來訓練兒童的目光接觸、身體接觸、等候及分享等基本社交能力。
（6）溝通能力訓練 ——主要訓練兒童的語言理解及表達能力。

工作人員的協調及分工

小組的統籌及協調工作由中心主任負責，訓練內容則由治療師、幼兒工作員及社工策劃，其間顧問心理學家亦在有需要時給予適當的意見，至於家長、義工及護士則會在小組進行時加入協助兒童學習。

家長的參與

家長的參與對訓練自閉症兒童是十分重要的，具體來說，他們的參與有不同的層面及形式，其中包括：

（1）被動 —— 家長藉着接受中心職員的輔導以及觀察兒童在中心接受訓練的情況來學習教導自己孩子的方法。

（2）主動 —— 家長參與活動小組的進行，並主動與其他家長分享感受及經驗。

（3）積極 —— 家長把訓練兒童的活動帶回家中進行，當遇到困難時，能積極地尋求解決辦法，不會只是倚賴中心職員的協助。

透過積極的參與，家長就更能接納自己的孩子，並能促進孩子把所學的技巧遷移至家中運用。

總括

自閉症兒童活動小組只是整體訓練的一個小環節，小組的訓練必須配合中心的訓練，並且需要透過在日常生活中重覆練習，方能鞏固兒童所學的技巧，並遷移至家中運用，在這個訓練的過程中，家長的積極參與是相當重要的。

THE CATEGORIZATION OF CHILDREN WITH SPECIAL EDUCATIONAL NEEDS

Louis R. Jasper

Before launching into a presentation on the topic of categorization of children with special educational needs, it seems appropriate to give you some personal background so that you at least receive what I have to say within some context. Much of my training and experience in the field of special education, beginning more than thirty years ago, has been with institutions and programmes which had adopted the practice of categorization. Whether or not the practice had been adopted consciously or spontaneously is difficult to say. I also come from the land of Public Law 94-142, All Handicapped Children Act of 1975, which was intended to guarantee all handicapped children in America the right to an education in the least restrictive environment and mandated the introduction of the IEP, the Individualized Education Plan, for each handicapped child. I worked under that law from 1975 until I returned to Hong Kong in 1981. To say that these varied and sometimes conflicting experiences have had an impact on my position concerning the topic before us for discussion would certainly be an understatement. I will do my best not to reveal too much of my personal bias, but rather play the devil's advocate and share with you what the organizers of this symposium have requested in terms of a positive presentation concerning the categorization of children with exceptional educational needs. Although most of the examples used in this paper are from the field of education for hearing impaired children where much of my personal experience has been, I hope they can be generalized to programmes for other disabilities, as well.

Categorization of children with special needs in its most basic form refers simply to the grouping of children for educational purposes according to their handicapping condition or the corresponding label which most closely fits their present observed state. That is to say, hearing impaired children will constitute one category, blind children another, physically disabled another, and so on. For example, the Hong Kong Society for the Deaf and all four schools for the deaf in Hong Kong have pre-school programmes which limit their enrolment to children with a certain level of impaired hearing. They do not accept children with normal hearing into their pre-school programmes for at least two reasons, the first being conformity to regulations and the second a conviction that the parents of such children would not want their children to attend these programmes.

More finely tuned categorization may exist within each classification so that children with similar degrees of disability, or preferably levels of ability will be grouped together. This practice exists in the Mongkok Lutheran School for the Deaf which operates a number of special ungraded classes for students with problems in addition to impaired hearing who cannot cope with the demands of the graded classes. The Lexington School for the Deaf in New York operates a more elaborate system of categorization which, in addition to the regular academic stream, includes what are called "vestibule classes" for children who need more assistance for a limited period of time to enable them to move back into the classes of the academic stream, and another work/study type programme which focuses greatly on living skills, communication skills, very basic mathematics, and other lessons which prepare the students for work and independent living.

Categorization seems to come naturally and some educators are avid in their adherence to the concept. It seems perfectly logical and it is certainly a practical approach to a very difficult educational task. The concept is readily applied in the education of non-handicapped children as evidenced by the grouping

of children in academic streams. It is only logical, that the concept should also be applied to special education.

The concept of categorization involves a number of underlying assumptions. Categorization assumes that a homogeneous grouping of children is desirable and to some extent achievable. It assumes, especially at the pre-school level, that there is a reasonably reliable mechanism for the early identification of children with special needs. This includes adequate and reliable diagnostic instruments and services. Of course, the younger the child, the more difficult the diagnostic process becomes and the less reliable the results.

In order for categorization to be implemented within a particular classification, certain conditions must exist. The educational programme must have the freedom to select its student population from a large enough pool of applicants and preferably it should be of sufficient size as to have a number of classes at each grade level. One famous school for the deaf in the United States which has a reputation for producing students who communicate orally without the use of sign language has had such a waiting list of applicants that if a child, after being accepted into the programme at the pre-school level, did not demonstrate the desired aptitude and required level of cooperation for developing oral communication skills, he/she was replaced by another applicant.To be sure, this seems like an extreme application of the categorization concept, but in order for the school to achieve its objectives, a high degree of selectivity is essential.

It is basically true that a handicapping condition tends to accentuate a child's individuality, especially those conditions which involve communication disorders. Therefore, finer degrees of categorization must implement instructional strategies which bridge those accentuated differences among the members of the group.

Categorization is seen as almost a necessity and possibly the only option in any programme which has serious staffing limitations such as exist here in Hong Kong. Those limitations refer not only to the number of professionals and para-professionals in the classroom, but also to absence of any pre-service training programmes in the field of special education. In 1981 when I returned to Hong Kong from New York, I was one of 14 full time administrative specialists who had no teaching responsibilities on the staff of the Lexington School for the Deaf, a school with an enrolment of 360 students. In addition to those 14 administrators and specialists was a full time support team of audiological, psychological, medical, and social service professionals. A master's degree in special education was the minimum pre-service training requirement for employment as a teacher in the school. I am presently the supervisor of a school for 260 hearing impaired children in Hong Kong where no pre-service training in special education is required for employment and the only person on the staff without teaching responsibilities is the principal. Add to that the distressing fact that most teachers tend to teach the way they were taught rather than the way they were taught to teach, with the emphasis on rote learning, group recitation, and the teacher as primarily a dispenser of information rather than a manager of instructional strategies, categorization is the approach with which they are likely to be most comfortable and effective. I will naturally choose my most comfortable and supporting shoes to wear when I know I am going for a long and difficult walk.

Categorization facilitates lesson planning and group teaching. It even becomes cost efficient in terms of providing staff, facilities, and specialized equipment by minimizing duplication in these areas. Even though the Building Ordinance of Hong Kong requires that a special school for handicapped children be designed for complete access by all types of handicapped children, government departments exempt themselves from compliance with this ordinance when they are paying for the building, clearly a cost effective decision made possible in part by categorization.

Where categorization can be implemented to the point of homogeneous grouping based on ability, the possibility of better students being held back by less gifted members of the class is minimized. Students may be taught more as a group and less individualized instruction may be required.

The categorization approach of the day care centres of the Hong Kong Society for the Deaf is pretty much dictated by the parameters of the society's constitution. While the centres do not necessarily exclude a child with additional handicaps, impaired hearing must be the child's primary handicap and there needs to be a consensus that the centres have the potential for helping the child. The categorization approach of the Mongkok Lutheran School for the Deaf is largely determined by the policy and regulations of the Education Department of the Hong Kong Government. The school has a considerable number of students with additional handicaps. Many of these children entered the school during the pre-school years. In many of the children, the additional problem is not clearly defined or understood. While further categorization of these children does not take place during their pre-school training, students with additional handicapping conditions tend to be grouped in special classes as they get older.

Categorization does have its drawbacks and limitations. In the interest of time, I will mention only two very briefly. The first has to do with the problems related to the labelling of children and subsequent errors in setting goals and objectives for the children who are labelled. Someone has suggested that it would be far more appropriate not to label people, especially children, as disabled or handicapped, but rather refer to them as exceptionally challenged. Too often, the labelling of children which is associated with categorization determines what is expected of them rather than focusing on challenging each child to develop to the full extent of his/her potential.

The second problem with categorization to which I invite your attention is the perpetuation of prejudice toward these exceptionally challenged individuals. Not only does the practice of categorization deprive a greater segment of the general public of really getting to know fellow students with exceptional educational needs first of all as people very much like themselves in many ways, but it perpetuates the prejudice of the members of one categorized group toward the members of another. Hearing impaired young people in Hong Kong are frequently reluctant to receive vocational training or employment alongside someone who is mentally handicapped or physically disabled.

While I certainly have not presented a comprehensive coverage of the concept and implementation of categorization, hopefully this brief paper has adequately set the stage for the following presentations which will discuss some alternatives to categorization.

NON-CATEGORIZATION OF CHILDREN WITH SPECIAL EDUCATIONAL NEEDS

Wyman Chan

The Heep Hong Society for Handicapped Children has for many years been providing services to handicapped children. Today, I am honoured to have this opportunity to share with you our experience in the special child care centres where education and training are provided for pre-school handicapped children of two to six years of age. The range of disabilities of these children include physical handicap, moderately or severely mental handicap, autism, emotional/behavioural disorders, deafness, blindness, and other forms of developmental disabilities. However, the majority of our children fall within the realm of mental handicap with or without other additional disabilities. In most cases, the children have more than one area of delayed development or handicap.

Over the years, by interdisciplinary effort, as we strived to meet the growing demands for more places and to meet the changing needs of our children, a form of non-categorical approach has gradually evolved.

By "Non-categorization", we mean that pre-school children irrespective of their handicapping conditions are accepted into our centres and that a class is made up of children who are educationally delayed in one or more areas of development. We follow the developmental approach when we plan our curriculum or educational programmes. The children's respective educational and functional needs are met by Individual Educational Programmes drawn up by child care workers in consultation with the therapists.

Let us first examine why the non-categorical approach is favoured. Firstly, we believe, as supported by expert opinion, that young children progress through the same developmental stages despite their disabilities. Secondly, for very young children with developmental disabilities, it is often difficult to define the categories of handicap as common characteristics are shared by most disabilities. Moreover, it is well understood that labelling causes stereotypic expectations and stigmatization; and people tend to focus on the disabilities rather than the strengths. It is, therefore, better to focus on meeting the developmental needs of the children without putting too much emphasis on the specific diagnosis of their handicaps. There is, of course, also the historical factor that there was just not sufficient pre-school places for handicapped children to meet the increased demands as a result of the successful operation of the Comprehensive Observation Scheme and child assessment centres; and we had to accept children of different handicaps. Perhaps, a very practical reason for non-categorization is the sources of funds and referrals. Our centres receive 98% of funding from the Social Welfare Department. All referrals are monitored by the Co-ordinated Referral Systems for Disabled Preschoolers of the Department. In line with the recommendation of the Working Party on Pre-school Care, Education and Training of Disabled Children, children of all kinds of handicaps are referred to the special child care centres. Furthermore, there would not be sufficient manpower and facilities to have separate centres for each category of handicapped children; and, as the population of Hong Kong is fast spreading out to the new towns, there simply is not enough number of each category of handicapped children to fill the places of separate centres in the districts even if there are any such centres.

One would naturally wonder how the educational and training needs of such a wide range of handicapped children can be met. Although we accept children irrespective of their disabilities, some form of homogeneous grouping is necessary for planning of curriculum and activities, and for easy management in the classrooms. As a general guideline, the children of our centres are divided into four groups each with certain major areas of emphasis in caring and training. Following the stages of child development, the emphasis of training areas are:

(1) Gross motor skills/physical care, for the very young, the medically fragile, the severely or profoundly handicapped, and the clumsy child;
(2) Sensory motor training/self-care skills, for those who need basic self-care training such as toileting and feeding;
(3) Social/language/self-care skills, such as sharing, waiting, social games, feeding, and dressing;
(4) Language/cognitive and pre-academic skills, to help children in transition to special schools. The seating arrangements and activities are designed to be as close to those of a special school as possible.

Usually, a child's chronological age, his physical condition, his skill level and training needs are taken into consideration to decide on the suitability of grouping. When a child is admitted, the child care worker who is responsible for him will help him settle in and spend a period of two weeks to observe and assess his level of functioning and developmental needs as a baseline for planning an Individual Educational Programme. After a period of implementation of the educational programme, a further assessment is carried out to determine the success of the programme and the cycle of assessment-planning-implementation is repeated.

The format of teaching and daily activities in the centres include group sessions/circle times which focus on subject instructions; and small group sessions which, through structured and unstructured activities, encourage social interaction of the children. There are also other activities, such as table toys and play times, music sessions, art and craft sessions, sand and water play, gross motor activities, and out-door activities, etc. All the activities or lessons are adapted to suit each group's level of competence and educational needs. Individual training sessions are scheduled for each child so that whatever individual needs which cannot be met in the group will be met during these sessions. Training of social skills and self-care skills such as toileting, dressing, and feeding are integrated into the daily routines such as meal times, cleaning,before and after nap times. With the advantage of having the support of occupational therapists, physiotherapists and nurses, an interdisciplinary team approach is made possible. Individual treatment sessions and special training groups such as gross motor training groups, sensory motor groups, autistic groups etc. are provided. If we are lucky enough to have a speech therapist on our staff, we also provide speech training sessions or groups. In addition to one-to-one or group therapy sessions, the therapists and nurses also involve actively in giving advice to the child care workers as well as participating in the daily self-care training programmes such as feeding and toilet training. Through informal meetings and regular conferences, the development and progress of the children can be carefully monitored. This way, there is less chance of overlapping in areas of training, better co-ordination, and all aspects of the child's growth needs are taken care of.

Here I would like to mention that we have quite a number of profoundly handicapped and physically handicapped children. They need a variety of special seats or training equipment which take up a lot of space in the classrooms. When active, ambulatory children and non-ambulatory or physically handicapped children are in the same classroom, free movement is often affected. It is very important that special consideration and care must be taken in relation to the safety measures of the physical setting, such as the arrangement of equipment and classroom furniture, or adding corner guards to tables and paddings to sharp edges.

The significance of parents' involvement cannot be over-estimated in the overall development of the children. Our ultimate goal is to improve the general functioning level of the children to prepare them for transition to special schools or, in some cases, to special classes in regular schools or to integrated child care centres. The parents may be invited to learn certain training skills or join in a special training group so that they also become teachers of their own children. They may be requested to carry out home programmes so as to facilitate generalization of skills learned in the centres, in the home environment and in the community. Although most parents are willing to participate in the training of their children, due to various reasons, we are not always successful in engaging all of them. Some of the parents have younger children to look after, or long working hours. Others are inadequate in parenting skills. Still others are not able to face the reality of their children's handicaps. These parents have to be given support with patience and understanding. In time, when they see the changes in their children, they will become more motivated and involved.

From our experience, we have noted many advantages of the non-categorical approach but inevitably there are also many hurdles of difficulties we have yet to overcome. The following chart consists of some observations shared by early childhood special educators and parents. The list is by no means exhaustive, and is not supported by any research.

	Advantages	**Disadvantages**
From the child's perspective and parent's point of view	1. more chance for social interaction and stimulation from other children with different disabilities and level of functioning 2. more chance for modelling 3. avoid labelling prematurely so as to minimize stereotypic expectations & stigmatization 4. increased community concern and support 5. focus on child's developmental needs	1. child may imitate undesirable behaviour 2. child may be held back by lower functioning children 3. safety for physically handicapped children has to be guarded 4. fear of ridicule by higher functioning children
From administration's point of view	1. flexibility for grouping 2 fewer argument over placement setting 3. flexibility with staff deployment 4. promote team work	1. more stress for staff as they have to handle a wide range of disabilities 2. team work must be strong
From staff's point of view	1. learn from process of team work 2. have opportunity to work with different kinds of handicaps so as to expand own horizon and experience 3. by rotation, the child care workers take turns to look after physically handicapped children so that chance of low back pain can be reduced	1. difficulty in planning for a wide range of disabilities 2. may not have adequate knowledge or skill to handle children with specific needs, e.g. C.P., deaf, blind, or autistic children

Early childhood special education is a fast expanding field. The trend of development is set for non-categorization. Demand in the quantity as well as quality of service is bound to increase. No doubt those who are in the frontline as well as those who are in planning have to work hard to meet these demands. They also have to keep abreast with the current development of knowledge and skill so as to maintain good quality of service. To this end, support from the policy level is necessary and I would like to call the attention of the policy makers to the following. As it is, most child care workers are generalists whose basic training in child care and special child care may equip them to handle disabled children in general. However, they may not have sufficient skills to handle children with specific needs, such as blind, deaf, cerebral palsied, or autistic children. And it is often in such circumstance that the need for more knowledge in-put and support from a special educator or psychologist is greatly felt. The provision of advanced in-service training in specific areas, refresher course, or inclusion of a special education expert in the staff would certainly solve the problem. Further, academic study or research of the current practices in non-categorization should be encouraged to guide future developments in the perspectives and curricula of early childhood special education.

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CATEGORIZATION VERSUS NON-CATEGORIZATION — ITS IMPLICATION ON THE TRAINING OF HANDICAPPED CHILDREN

Lee Tsor-kiu

Definition of Categorical Education

The Encyclopedia of Special Education (1987) defines categorical education as the practice of separating handicapped children into subgroups representing different types of disability. Each subgroup bears a specific categorical designation and its members are reviewed as cohesive group for instructional purposes.

Categorization of Disabled Children in Hong Kong

In Hong Kong, the Rehabilitation Programme Plan classifies disabilities into five major categories, they are the deaf and partially hearing, the blind and partially sighted, the mentally ill, the slow-learners and the mentally handicapped, and the physically disabled. In the provision of education for children with disabilities, the government basically follows a categorical approach and divide these children into more of less the same five categories. Therefore we have special schools catering for each of these specific groups. The rationale behind the categorical approach, I believe, is more of administrative consideration. It is obvious that some of the needs of each specific group are unique and they deserve special attention. For example, the teaching of braille and the provision of equipment for braille communication are basically only relevant to blind and partially sighted students. The installation of sound tracks and amplification equipment in classrooms seems essential to a school for deaf and partially hearing children but not to schools for other disability groups. And of course, sometimes staffing and utilization of human resources may seem to be more economical and efficient with categorical education. Therefore funding bodies always find it simpler to decide on the amount of financial support for schools with a categorical approach.

Definition of Non-categorical Education

As far as teaching or training is concerned, we are not quite sure whether categorical or non-categorical education is more effective if we are not going to analyse how exactly do teachers teach and what kind of progress the children make in these two types of schools. But first let us clarify what do we mean by non-categorical approach. If we follow the definition of the Encyclopedia of Special Education on categorical education, non-categorical education may mean the practice of not separating handicapped children into subgroups representing different types of disability. This clarifies that we are not discussing on integrated education whereby children with disabilities are mainstreamed into the regular system for ordinary children. We are comparing schools for children with one specific type of disability and those in which children with different disabilities learn and are taught together in one classroom.

Non-categorical Settings in Hong Kong

In Hong Kong, to my knowledge, there seems to be no special school using non-categorical approach,

except that there is a trend for schools for the physically handicapped to take in pupils with a greater variety of disabilities, but still, the major disabilities of these children are assessed to be physical ones. I think, in the local scene, only early education and training centres and most special child care centres take in children indiscriminatively of the types of disability they have, but if we consider that early education and training centres use basically a one-to-one teaching approach and children enrolled in the same centre are seldom grouped together for training purposes, they are actually not using the non-categorical approach. They just take in children non-categorically. Then special child care centres seem to be the only places where non-categorical education is being practised.

We have just heard from Dr. Jasper and Mrs. Chan on how their school and child care centre use the two approaches. They have given a detailed account on the strengths of the approaches and how they resolve some of the difficulties they encounter in using these approaches. I think I'll just summarize and perhaps elaborate on the points they presented.

Similarities in Teaching Strategies of The Two Approaches

I would like to discuss on how to teach with the two approaches. In analysing what is happening in the categorical schools and non-categorical child care centres in Hong Kong, we find striking similarities in the teaching strategies they use. For examples, they stress on individualized teaching, they assess children individually and tailor individualized education programme for each of them, they use one-to-one teaching and small group teaching interchangeably in order to cater for learning needs they have therapeutic services, etc. In fact, we have just heard from Mrs. Chan that they have some kind of categorical grouping within her non-categorical centre. We can see that they are no longer restricted by a particular approach but would make creative adaptation of it in order to serve the needs of the children.

Presumption of Categorical Approach And Weaknesses of It

However, traditional categorical education presumes that there is significant homogeneity of learner characteristics within each disability group, and such presumption usually underestimates individual differences which are very important educational consideration. For example, within a group of children who are assessed to be moderately mentally handicapped, there may be a very wide range of performance in comprehension, communication, social and self-care skills, sensory and motor functioning, etc. And of course, the temperament, the character and the learning habit of a child also affect the way he/she learns. In order to facilitate effective learning, individual differences must be taken into consideration.

Moreover, now we understand better that human development is multi-dimensional and modern concept of education attempts to address to all areas of development instead of focusing on cognitive development only. For most children with disabilities, there is obvious intra-individual differences, i.e. a child may develop in different pace in each of the developmental areas. Such intra-individual differences make each child even more unique. If we just consider the disability with which the children are labelled and plan teaching collectively, we are not just overlooking individual differences but also the interacting effect of development in different areas within a child.

How a child is being categorised by types of disability in fact tells us very little about how to teach him/her effectively. I think it is with this understanding that in the field of special education, individualized eduction has been vigorously advocated. But with individualized education, it does not imply that teaching and learning have to be taken place in a one-to-one situation. There are in fact many advantages to teach children with disabilities in groups. Children interact and stimulate each other. Group atmosphere encourages them to participate and to act out spontaneously. As far as the comparison of categorical and

non-categorical approaches is concerned, I think group teaching may deserve more discussion than one-to-one teaching.

Group Teaching in Non-categorical Setting

We all recognise that in a non-categorical group, children are more heterogeneous. Therefore the teacher must design carefully the activities he/she is going to use in the group so that every child in the group can participate. Sometimes the teacher may not always find it possible in doing so, especially when the disabilities vary very much among the children. For example, one may find it difficult to involve a deaf child in a music programme or to invite a cripple child to race with other children with normal motor functioning.

Group Teaching in Categorical Setting

We may tend to think it is easier to design activities for a categorical group because their major disability is obvious so we can design activities in which their disabilities would not be an obstacle to participation. Perhaps this is true but think about the effects of such activities on the children. If we try to prevent the children from exposing their disabilities, they never learn how to overcome them. One of the possible disadvantages of categorical approach is that we tend to be too sensitive to the type of disability the children have. The disability, not the children, has become our focus of attention.

Designing Activities for a Non-categorical Group

Designing activities for a non-categorical group is not difficult, although we need to be creative. Sometimes it is not the activity itself that has to be adapted but the way of participation by each unique child. Some children see things or hear sounds better, others speak more fluently and understand things better, some walk and run faster, others are more expressive of feelings and emotions. But we have to make sure that all children learn to observe, conceptualize, communicate, move around, get along with people, etc. Children learn by active participation as well as by passive observation. In a non-categorical group, some children may not be able to participate fully in every activity that the teacher designs because of their disability, but by observing and sharing the experience vicariously with other children, they are able to grasp what is being taught.

Training Needs of Teachers Using Non-categorical Approach

Teaching a non-categorical group is challenging and requires high creativity. One of the most common difficulties is concerned with the training of the teachers. Very often, the training for special school teachers follows a categorical approach. Teachers specialize in teaching a particular type of disabled children. Therefore when facing a non-categorical group, teachers may find themselves not knowing enough about the special needs and characteristics of each type of disabled children, and thus they may find it difficult to accommodate all these needs appropriately.

So do children progress faster with non-categorical approach? We are not very sure, it is not easy to get hold of comparable data to draw a conclusion. I speculate that children taught with such an approach would become more dynamic in problem-solving strategies, they understand better and are more accepting to persons who are different from them, they have more opportunities to be helpful and to receive help among classmates.

Then do children taught with a categorical approach receive none of these benefits? I don't think so. It depends on what and how they are taught. Just like many of the special schools with a categorical approach in Hong Kong, they are successful in overcoming many weaknesses of a traditional categorical approach.

Applicability to Early Education

One last point on the implication of using the two approaches on early education for disabled children. Disabilities in children of tender age are not easy to define and assess. Moreover, sometimes the complexity of their disabilities makes it difficult to categorise them in any disability group. In some cases the nature of disability changes as the child develops. Placing this kind of young children in any categorical setting may hinder an all-round development.

Summary

Let me summarize and conclude here. There are advantages and limitations in both categorical and non-categorical approaches. We recognise that with categorical approach, there are many administrative conveniences, both financial and human resources may be developed and utilized more economically, the special needs of the children arising from the disability they are categorised are being met with more effectively. However, the individual needs and characteristics of these children may be oversimplified, they may also become less flexible in getting along with people who are very different from them.

In non-categorical settings, children go through a more enriched experience because of the variety of characteristics among them. Since the teacher is not focusing on alleviating a particular type of disability, children may receive a more balanced learning experience. And because of the wide range of learning characteristics among the children, it is more likely that the teacher would adopt an individualized educational approach, and with which the individual differences of the children are better dealt with. for very young children with disabilities, non-categorical setting may be a more appropriate placement for them. It has less labelling effects and may provide a more all-round training for them. However, it requires more for a teacher to teach in a non-categorical setting. If teachers' training is inadequate to enable them to teach more flexibly and creatively, many teachers may find it difficult in carrying out their duties in a non-categorical setting.

Conclusion

My conclusion is that many of the shortcomings of the two approaches can be eliminated. It depends on the sensitivity of the school system to the collective and individual needs of the children, and the creativity of them to meet with these needs.

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SOME THOUGHTS ON THE PREVENTION AND MANAGEMENT OF BEHAVIOURAL PROBLEMS IN SPECIAL CHILD CARE CENTRES

Agnes Ma

When I began to prepare for this talk, I was reading a study by Tobin, Wu & Davidson* (1989) comparing the practices and philosophies of preschool education in Japan, China and the United States. The authors videotaped a preschool in each culture, then showed the tapes to preschool staff, parents and child development experts of the three countries for analysis and appraisals of their own and each other's preschools. Multicultural differences in preschool education are made explicit by comparison and discussion.

The tapes on the Chinese preschool were made in mainland China and the discussion was consequently made at the time of the study and in the context of mainland China in the 80's. As pointed out by the authors, the tapes are both a reflection of Chinese culture and ideology of the Chinese communism. However, the authors have also gone further to disentangle the influence of Chinese culture by comparing preschools in Taiwan, Hong Kong and other Chinese communities, and note certain distinctive features across which have their roots in traditional Chinese culture. These include a focus on regimentation, control and order for children; a concern with correcting spoiling caused by overindulgence from the parents; an emphasis on academic achievement and group ethos; perseverance in learning activities and great attention to eating well and properly. Perhaps with a few exception, these features are also found in our local preschools which have in addition incorporated ideas derived from Anglo-American educational and child psychology. It is therefore not uncommon to find Western-style play materials and learning activities on the timetable, mingled with Chinese ways of interacting and working with children in practice.

I have referred to Tobin *et al* and the general situation of our preschools as a preamble because when we talk about behavioural problems of handicapped children we cannot isolate the child or his problems independent from the larger context of the preschool and the people in it. Afterall, a problem may be as part of the child's behaviour as that of the adults' or other children's. This is especially true in an educational unit in which the child comes into contact with more than one adult to whom he may be significantly related, and in which differences in opinions on how best to handle his problems is the norm rather than the exception.

Among the several features mentioned by Tobin *et al*, perhaps the one on regimentation, control and order has caused the strongest reactions from those who advocate for a respect of the child's free choice and spontaneity, for letting the child to direct his own learning at his own wish. While such views have their own merits, for those of us who have become too familiar with some of the problems our handicapped children may run into, there is some food for thoughts in what appears to be essentially Chinese.

Some of us may feel proud of the amount of formal instruction we give to our four-year-olds in teaching them the 3 Rs even before they start school, and how hard we try to get our handicapped children to sit down to read and to count just as what their normal peers are doing. While we put such an emphasis on academic attainment as a goal in normalising our handicapped children, have we not something to learn from a more balanced educational model of enhancing a child's social and emotional development alongside with academic learning?

* Tobin, J.J., Wu, D.Y.H., Davidson, D.H. (1989) Preschool in Three Cultures: Japan, China and The United States. Yale University Press.

So frequent have we heard of the use of behavioural techniques in managing handicapped children's problems and hear complaints that they do not work in real life, as if all the successful examples we talk about occurred only in the psychologist's head, or remotely in his laboratory, or in places and with people outside Hong Kong. But have we ever noted how accurately a technique has been understood? How closely and consistently a plan of action has been followed? How high our expectations have been?

Perhaps when we sit back and examine in greater details the decision-making process in a team on solutions to a child's behavioural problem which give some positive results, we may find that it is a nice blend of what is good in Chinese and the West, of what is theoretically sound and practically possible.

I would like to share with you some attempted solutions to one of Tim's behavioural problems that had been a cause for concern to his family and his centre. Tim was a boy who bit since he began to walk.

Tim was two when he started at a special child care centre. He was delayed in his overall development, preferred to sit in one spot and engaged in self-stimulatory activities such as kicking feet and flapping hands. He showed little interest in toys. Play patterns were stereotypic and primitive. He showed special preference for his mother but did not actively look for her when she went out of sight. He vocalised unintelligibly but made no attempt to communicate. He threw temper tantrums whenever he was frustrated. But he could be pacified easily and was a cheerful child when he was in stable mood.

Tim's targets ranged from his soft toys and pillows to his mother or another child. His bites could be so intense that they left his victims with teeth marks and purplish bruises. Tim also had a habit of mouthing and licking his own hands, and initially the mother would put Tim's hand in his mouth when he bit. As Tim was a difficult child, the mother had got out of way of dealing with him.

The child care centre was the first place where Tim received his instructions from adults other than his parents, and mixed socially with children other than his brother. Tim's day in the centre was spent in adherence to a well-planned timetable of learning and activity sessions each lasting for thirty to forty-five minutes. The educational regime, as one could observe when the programme was in session, was typically regimented and structured by western standard. Children were made to follow directions and to learn to behave properly.

Tobin *et al* mentioned that the word used frequently by Chinese teachers to refer to their control and regimentation of children is "guan" (管) — literally means "to govern", which also has a positive connotation of "to care for". In fact, we do speak of "guan" (管) and "gow" (教), i.e. to govern and to teach, or to govern in order to teach. If the teachers are to govern the children well, they are to monitor and correct the children's behaviours continuously.

The elements of governing prevailed in the staff-children interaction and evidently children are made to follow the centre routines and rituals such as lining up to go to toilet, leading by the child care staff to go from one place to another, sitting in chair and wait to be invited to take part in an activity, raising hand before taking one's turn. In itself the staff-children interaction has imposed an order and quite firm control over children's behaviours in ways similar to educational regime based on behavioural principles. Inherent in our culture, therefore, we have something akin to approaches to the prevention of behavioural problems deriving from behavioural psychology.

Just as most other children, Tim was able to fit himself into the routines of the centre. However, his behavioural problems, biting in particular, persisted. His targets were other children in the centre and the staff were very concerned about the situation. Attempts were made to deal with his biting, and much of the initial efforts were on eliminating the behaviour. These included placing him away from other children during group activities when adult supervision was minimal, immediately pulled him out from the group

after he had bitten or was about to bite, pressing his lips to close his mouth and withdrew all adult attention to him. The mother was also asked to work closely with the centre to deal with the problem. Medical advice was sought and it was noted that his problem was "behavioural".

As part of a more systematic intervention, I observed Tim when he was in a group of about ten children taking part in an activity involving the use of the senses. Tim was able to sit still, look at other children as each of them took turns to go in front of the group to play with the materials. With a great deal of manual guidance from the child care staff, Tim was able to play with the materials in similar ways as what other children in the group had been doing. I was sitting at his back, and found that during the thirty minutes session, he attempted to bite ten times the girl sitting next to him. Once he nearly bit on her shoulder, others were attempts to grab her arm to put his teeth on. All his attempts failed as I managed to physically restrain him before he advanced further. Tim was in fairly stable mood, and I was unable to note any unusual events occurring before he made his move. Similar observations were made of him by other staff who were involved in working with him. But Tim also bit when he was upset.

I was at the same time reviewing Tim's whole day programme and also found that disregarding his outbursts of behaviour problems, he could dutifully follow the routines and rituals of the centre. In one-to-one session, he was trained to perform sensori-motor skills with drilling and a great deal of manual guidance from his child care worker.

It then occurred to me that Tim seemed to have got lost as an individual in his group and the routines and rituals, although just as all other children in the centre, he had an individualised educational plan. As part of the intervention strategy, and aiming at some more long-term goals for him, I suggested more deliberate teaching of two to three pieces of constructive behaviours — taking the initiative to indicate his preference by pointing; making contact with another child through slight pats; and encouraged him by his child care worker paying extra attention to him after a specified period of time during which he made no attempt to bite. These activities were incorporated into the programme in the centre throughout the day.

As Tim had very limited skills on his own, his child care worker had been skilful enough to rely on the use of operant techniques, with physical prompting when necessary. The solution at this stage was to shift our focus from eliminating the undesirable behaviour to trying both to teach Tim more constructive behaviours and at the same time reducing his biting. Technically this strategy came from the behavioural principle of "differential reinforcement of other behaviour' and in the Chinese context we were trying to "govern" and to "teach" Tim. However, it was not information or academically related skills that we were teaching. Our concerns had been with developing Tim's skills as a growing little person who would initiate and communicate appropriately.

The intervention went on for about a month, and it was carried out by Tim's child care worker. Not surprisingly, Tim's progress in learning the constructive behaviours was painstakingly slow. His biting persisted and when the intervention programme was reviewed, "He still bites" was the remark.

A case conference joined in by the therapists, social worker, Tim's child care worker, the centre-in-charge and myself was held as anxiety and tension mounted in the handling of Tim's problem. Aversive means of eliminating Tim's biting were raised by the team members. One of these was to hit his mouth after he had bitten. Considerable discussion was held, and it was finally decided that they were inappropriate means of stopping Tim's biting. Firstly, the centre was an educational unit and what had been suggested were considered to be psychologically and/or physically damaging to the child. Secondly, we had also gone to the consideration that even if these measures were to be taken, more aversive means of punishment had yet to be introduced if they failed. But we were of the opinion that some aversive means of dealing with his biting needed to be introduced as the behaviour was damaging to other children and the centre had also a responsibility to the victims' parents. Other alternatives were also explored and

discussed. The solution we came up with in the end was to wipe lightly Tim's neck with a brush immediately after he had bitten. The brush was chosen as Tim showed an aversion to brushes. We avoided to wipe it direct or near his mouth in case that the aversive effects would affect his feeding. We had also asked Tim's mother for her approval to try this.

Tim's child care worker was the one who implemented the plan. More deliberate attempts to teach Tim constructive behaviours also continued as before. While she was working, Tim's worker carried with her the little brush and Tim's bitings were recorded on a simple form designed for the purpose, and the following recording was obtained:

Day	No. of Times Tim Bit
1	2
2	2
3	4
4	5
5	3
6	1
7	1
8	0
9	1
10	1
11	1
12	1

After the twelfth day, biting reduced to zero. In a review meeting held two weeks after, some positive comments were made: Tim had stopped to bite; his intention to bite had also lessened. He had shown interest in making social contact with other children and was beginning to communicate. For some time Tim continued to make slow but gradual improvement until he changed to another centre when his problems re-appeared as before.

Time and space do not permit me to go on with what happened to Tim in the other centre. What is being reflected in the example of Tim is the possibility that in an educational setting, solutions to a child's behavioural problems can also be an integral part of his educational and training programme during the day, although extra efforts need to be put into the planning. It appears that the more distinctive we try to isolate a problem away from the overall learning and development of the young child and the educational context he is in, the less we are able to achieve.

The Chinese idea of "governing" and "teaching" the children does have a point in our work with the handicapped children in our special child care centres. However, what we need is something more than making children followers of our routines and rituals. The handicapped children need to be treated as individuals, and this comes mainly through deliberately teaching them when to initiate and how to interact as individuals.

Similarly, when we move out from the restricted frame of mind of directing our teaching efforts to academic or academic-related skills, we shall be able to see more of the child as a person whose behavioural problems can be tackled from a much wider perspective.

When we talk about skills in handling behavioural problems in special child care centres, the behavioural approaches seem to be the most often used. However, they have also invited the comments that they are rigid, mechanical and too unnatural for use in real life — although the crudest form of "B-mod"

is popularly used and represented by the giving of crisp and sweets in large portion as rewards any time during the day.

The behavioural approaches can be rigid and mechanical when we use them as means to gain control over a child, in similar way as we train rats to press a lever in laboratory experiment. But as practical ways of getting through our messages to the child, the behavioural approaches are means of helping a child to form a simple relationship between what he does and what is required of him. They are also ways to help us to be more exact in our thinking, language and actions.

As adults we often fail to appreciate how difficult and confusing sometimes our spoken messages can be. Even when we give clear and good explanation, most of our handicapped children do not have the necessary verbal comprehension and cognitive abilities to grasp the message. For few of those who can talk, a change in their verbal behaviours, saying what to do, what not to do, occurs more evidently than a genuine change in his problem behaviour. They know what to say, but they do not do what they say.

When a child screams to gain attention and finds that the more he screams, the more attention he will get as the adult shouts back at him the message he gets is "scream - - - attention". When he screams, the adult turns away and returns to talk to him when he quiets down, he learns the message "quiet - - - attention".

When a deaf-blind child slaps her hand and bangs her head, she is made to put on a specially designed padded helmet and mittens and to sit in a chair without injuring herself. When she is not injuring herself for ten minutes, she gets a few strokes on her cheeks — something she likes very much. Technically, this procedure involves a combination of "timeout", use of protective equipments and "differential reinforcement of other behaviour". As the sensory experiences of hand slapping and head banging are removed, and the pleasurable experience of being stroked increases when she stops injuring herself, the child learns to reduce to slap her hand and bang her head. In this way, our message to the child that: "hand slapping and head banging do not lead to sensory experiences and not engaging in such behaviours leads to something pleasurable" is conveyed to the child not through verbal explanation, reprimanding, or drilling but by our immediate reactions to what he has immediately done.

The prevention and management of behavioural problems in special child care centres is never an easy job as every child has his or her own needs to be attended to and every staff member is busily occupied. Even after a plan of action has been designed and agreed on by everyone, we still have to decide such things as who pulls the child away from the group when he misbehaves? Who withdraws attention from him (as there are so many adults and children around)? Who makes sure that the plan has been carried out and properly followed? Who will take charge of the situation when all the adults are engaged with activities for other children and the child is left with a group of peers some of whom have other problems?

In preventing and managing behavioural problems in special child care centres, an accurate understanding and mastery of behavioural principles and the skills by the staff is essential, so is a general consensus of a balance between what is best for the child and practically possible for the centre. This would often mean some frequent re-considerations of our attitudes and constant reflections on our existing practices.

MANAGEMENT OF BEHAVIOUR PROBLEMS

Lyn Gow

Preface

Thank you for inviting me to speak today. It is great honour to be associated with so many prominent people in the field of handicap, both from abroad and locally. I only hope that my paper can add to the knowledge already provided by my knowledgeable and eloquent colleagues.

I had the great pleasure and advantage of reading the papers of our key speakers, Professor Michael Rutter and Dr. Michael Guralnick, some weeks before the conference. While reading them, I found myself nodding my head in affirmation because so many of their comments related to the topic of my paper. Dr. Guralnick's paper addressed the importance of integration and individualisation of treatment for young handicapped children. He also underlined the need for staff development and a multidisciplinary approach (as mandated by the new Public Law in the U.S., 99:457) and pointed out that structure in the curriculum for young children with handicaps was becoming more subtle and less directive. Professor Rutter reiterated these issues and provided a comprehensive summary of the behavioural and educational methods constituting the mainstay of current treatment approaches. He underlined the need for educational decisions to be made on an individual basis and for parents to be partners in the educational process. I found, as a result of the comprehensive of the coverage of these issues by Professor Rutter and Dr. Guralnick, that I needed to modify the content of my paper so as to avoid unnecessary duplication.

In my paper, therefore, I intend to provide a brief outline of the major features of several different approaches to the management of behaviour problems in young handicapped children. I will then point out that the approach most typically used is the behavioural approach which has already been discussed in detail by Ms. Agnes Ma in the previous presentation. I will proceed to pose the question as to whether this approach has been successful and I will argue that it has failed in one significant area, that is, in the promotion of generalisation of behaviour change. Conscious of my time constraints, after briefly defining generalisation and explaining its significance, I will provide an overview of some strategies that can be used to promote generalisation of behaviour change (although I will refer members of the audience to other references for additional information). In the conclusion of my paper, I will reiterate several points in support of my colleagues, Professor Rutter and Dr. Guralnick.

Introduction

Behaviour problems are, in many ways, the most difficult challenge facing the teachers and parents of handicapped young children. It is the case for teachers and parents alike that they can either sink or swim in trying to manage a child with behaviour problems, although it is also fair to say that some tread water for years on end. For many, behaviour problems seem like an endless ocean and contribute more to parent burn-out and teacher drop-out than any other educational problem.

Unfortunately, if you ask professionals the question, "What are the best ways of handling children with behaviour problems?", you will get many different answers. This is partly because there are so many

different behaviour problems, ranging from aggression to withdrawal and from mild to profound. But, the major reason for the different educational views is that there are many different conceptual models or theories. I will now attempt to summarise the key characteristics of the teaching methods which typify the main approaches; unfortunately, time does not permit me to elaborate on the theoretical underpinnings.

The Psychoanalytic Approach

The psychoanalytic approach to the management of behaviour problems has been formulated primarily by psychiatrists and clinical psychologists who believe that the guiding principles of psychoanalysis can be used in education. Educational practices are designed to uncover the underlying mental pathology in an attempt to improve psychological functioning as well as behaviour and, thereby indirectly, achievement. The approach relies on individual psychotherapy for child and parent and little emphasis is placed on academic achievement. The educational environment is permissive to encourage the child to act on his or her impulses.

The Psychoeducational Approach

This approach is a composite of psychiatric and educational approaches because it is assumed that behaviour problems stem from underlying psychiatric disorders and observable misbehaviour and underachievement. There is an emphasis on meeting the individual needs of the child and most of the teaching is done through projects or the creative arts.

The Humanistic Approach

This approach grew out of humanistic psychology and the open education movement. The assumption behind the approach is that children with behaviour problems are out of touch with own feelings and cannot find meaning and fulfillment in traditional educational settings. The recommended educational practices are designed to enhance children's self-direction, self-evaluation and emotional involvement in learning in non-traditional settings. The teacher becomes a facilitator rather than a director of activities and teacher and child work together as learners pursuing and sharing common interest.

The Ecological Approach

The ecological approach has been built from the notion that behaviour problems stem from interactions with the various elements of the environment (i.e. family, school and the community in general). Education must therefore focus on altering the entire social environment in which the child is enmeshed. The goal of this approach is not only to intervene in the child's behaviour but also to change the environment enough so that it will support desirable behaviour of the child once the intervention is over. This approach requires close work with the family, neighbourhood and community agencies, as well as with the child.

The Behavioural Approach

This approach is based on the principles of operant and respondent conditioning. Behaviourists believe that behaviour problems represent inappropriate learning and that these behaviours need to be modified. This is achieved through manipulating the child's immediate environment — the educational setting and the consequences of the child's behaviour. As the focus of concern is the child's behaviour, precise

measurement of this behaviour is required. Educational practices are clearly specified and analysed for their effects on the behaviour being measured. Sometimes prompts for appropriate behaviour and models of good conduct are also needed. More specific details of this approach are competently covered in the paper of Ms. Agnes Ma.

Which Approach Is Used Most Widely?

The behavioural approach has been used more widely by both professionals and parents largely because it is the simplest to use and typically has immediate effects.

How Effective Has The Behavioural Approach Been?

This approach has been very effective in bringing about immediate behaviour change but has not been as successful in achieving long-term behaviour change or change across settings. That is, it has failed to promote generalisation of the behaviour which has been effected during intervention. Unfortunately, if the desired behavioural changes do not generalise across settings, the effectiveness of the programme must be called into question. For maximum treatment effects, generalisation must be achieved.

How Can We Enhance The Generalisation of Behaviour Change?

What we do know from research is that generalisation will not be achieved unless we programme for it directly. We cannot just hope it will happen; we must be conscious of the need to include it as a programme goal and to actively teach for it.

We know from research that one of the most successful ways of teaching for generalisation is to promote self-management and individual responsibility. This point was made by Dr. Guralnick who stated that individual goals and objectives for the child are important, but curricula are becoming more heuristic thus calling for activities that build on initiatives and reinforce natural interactions. This approach is at odds with the behavioural approach described by Ms. Ma. Here we have a contrast which is crucial in the Hong Kong context. As Ms. Ma demonstrated, the two words which describe the education process in Hong Kong are "govern" and "teach". Both of these words are consistent with the behavioural approach. However, what contemporary research findings are showing is that we must move towards less directive means of education if we want to achieve generalisation.

Another strategy which can enhance generalisation is to teach in real-life, or ecologically valid, settings in collaboration with other key people in the life of the child, including peers and siblings. This point was made by Professor Rutter; families need support in the education of their children and a multidisciplinary team approach must be fostered.

It seems clear, therefore, that teacher and parent education are central ingredients in the successful management of children with behaviour problems. This is largely a matter of resource management to provide the necessary opportunities for parent and staff training. What is certain is that, as society changes and the thrust and emphasis of education evolves, teachers need adequate pre-service and in-service training and parents need regular training to keep pace with these innovations. Teachers and parents need to have a great deal of information and a variety of intervention strategies in their repertoire to adequately cope with the situations that arise in the day-to-day management of a child with behaviour problems.

Referring back to my outline of approaches, it seems to me that what is needed is an amalgamation of educational practices recommended by all of these approaches. No one approach will work for all children or for us, either. We must be eclectic; we must try different approaches and, if they work, use them. What we should avoid, however, is giving up on an approach before we have really given it a chance. We should strive for consistency in our management of children with behaviour problems, but at the same time we need to be flexible and innovative.

One final consideration is that we must ensure that we adequately monitor and evaluate the approach we are using, particularly with regard to its ability for promoting generalisation. Without adequate monitoring and evaluation, we cannot determine whether we are helping the child overcome the behaviour problems and we cannot judge whether the approach we are using is actually working.

Conclusion

Effective teachers and parents have the ability to minimise behaviour problems before they begin. Because children's behaviour is quite responsive to conditions in the social environment, the potential for "primary prevention" (i.e. preventing behaviour problems from occurring in the first place) would seem to be great. If parents and teachers could be taught effective child management skills, perhaps many of the cases of behaviour problems could be avoided. Moreover, if parents and teachers had such skills, children with behaviour problems could be prevented from getting worse.

The developing concepts in behaviour management of self-management and individual responsibility of the child need to be given more consideration. We must remember, however, that there is no one best approach, we need to be eclectic, that is try different approaches and if they work, use them. We must also ensure that behaviour change is achieved across settings, rather than in the treatment setting only. This requires that teaching takes place in the settings to which we want the behaviour to generalise and that parents and professionals work together, wherever possible. We should also ensure that our programmes are integrated within community settings, whenever feasible.

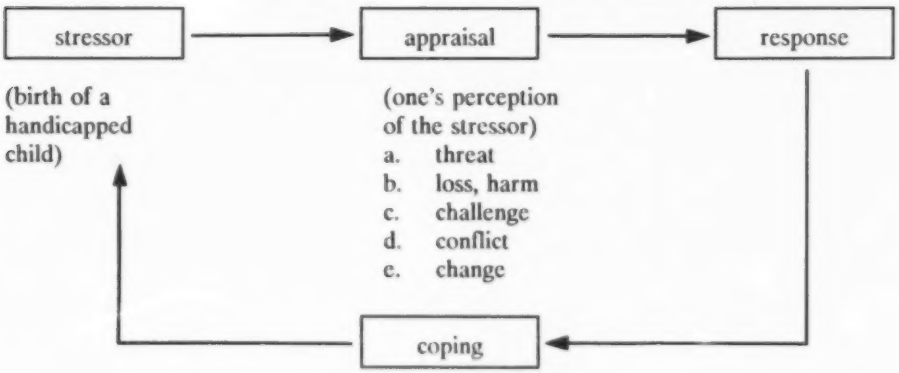
In conclusion, I would like to underline the fact that teachers need adequate pre-service and inservice training to keep pace with new ideas and parents need long-term support in educating their children. I would also like to stress the value of a multidisciplinary team approach. We all know that this is often hard to achieve, but we should not lose sight of it as a desirable goal.

HOW TO HELP PARENTS WITH HANDICAPPED CHILDREN? (Summary Notes)

C.K. Wong

Caring for such parents can be both tangible and intangible (e.g. emotional support).

Reaction of such parents to the birth of a handicapped child can be mapped as follow:



Possible reactions of parents with handicapped children:

anxiety, sadness, depression etc.

Once such feelings cannot be worked through, the following response may arise:

1. not able to accept reality:
   - missing the fantasized child that has never existed.
   - unrealistic expectation towards the child.
   - rejecting the child when it cannot achieve the expected progress.

2. recurring disappointment towards the child.

3. parent-child relationship being jeopardized.

4. guilt feeling:
   - sorry for causing the abnormality of the child.
   - sorry for bringing a suffering child to earth.

   → overprotect the child.

   → hatred towards the child and oneself.

   → shame.

   → low self-esteem.

Suggested handling method:

1. facing/accepting one's grievance.
2. ventilating the grievance through supports of others, especially other parents who also have handicapped babies and through expanding one's own social circle.

Skills to work with such parents:

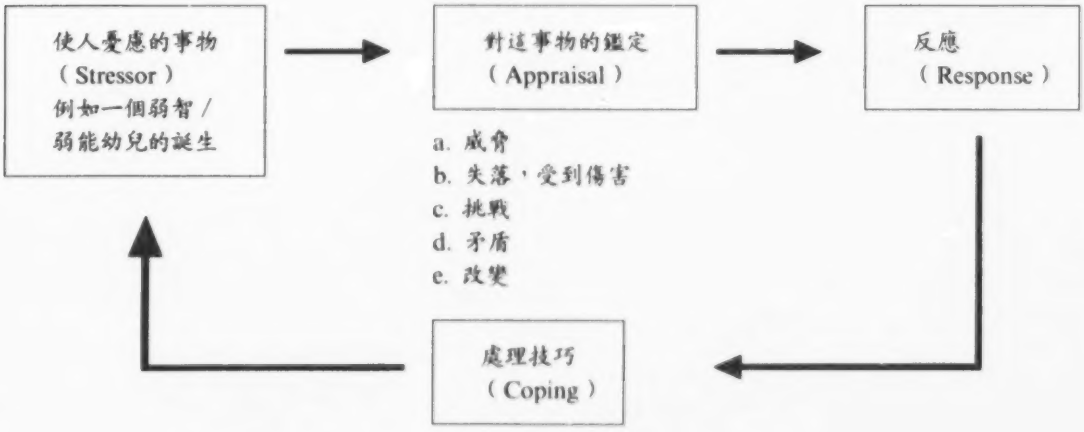
1. be an active listener and avoid too much direct teaching or confrontation.
2. be sensitive to their feelings.
3. employing probing skills.

如何幫助弱智／弱能兒童的父母
（內容要點）

黃重光

外界對弱智／弱能兒童父母的關懷，可分為有形和無形（如情緒上的支持等）兩類。

父母對一個弱智／弱能幼兒的誕生，會有以下反應：



如果焦慮，抑鬱、憂愁等情緒不能恰當地處理時，可能會產生以下反應：

1. 不能面對現實
   ——懷念幻想中而從不存在的幼兒。
   ——對幼兒抱有不切實際的期望。
   ——如果幼兒不能達到預期的進度時，對他產生抗拒。
2. 對幼兒經常表示失望。
3. 父母子女的親子關係受到損害。
4. 內疚：
   ——把幼兒的不正常狀況歸咎自己。
   ——把幼兒帶到世上來受苦。

   因而
   - 過份保護幼兒。
   - 厭惡幼兒及自己。
   - 感到羞愧。
   - 擁有極低的自我評價。

建議的解決方法：

1. 接受和面對現實。
2. 把積怨透過他人的支持抒洩出來。好像和其他弱智／弱能兒童的父母彼此分享等。同時也應擴闊自己的生活圈子。

面對這些兒童父母的技巧：

1. 做一個主動的聆聽者，避免太多直接教導或對立。
2. 對他們的感覺有敏銳的洞悉能力。
3. 運用探測技巧深入了解他們的感受。

一般教學方法和課程在混合/特殊幼兒中心之應用

龐劉湘文

一個在香港首創的聾童混合教育計劃的簡介

一九八一年四月宣美聾童語言訓練中心為香港聾童推行一個首創的聾童混合教育計劃。這些聾童在中心受訓兩年後，通常已能唇讀超過一千字彙及明白人的說話，符合了進入普通幼稚園的基本條件。他們在主辦團體屬下之宣美幼稚園，就讀得到幼稚園教師的配合，為將來混合教育奠定一個良好的基礎。

中心成立至今，現有 15 位聾童正在連繫的宣美幼稚園就讀，有 33 位聾童在普通小學就讀，另有 4 位聾童則在中學就讀。其中那些中學生及大部份學生已不再需要本中心的語言輔導。據統計，在中心受訓兩年以上而進入普通學校的聾童比率達百分之九十五。

混合教育的運作包括下列四類：

1） 早期聽覺測驗。
2） 個別語言、發音及聽覺訓練。
3） 家長輔導。
4） 混合教育及跟進工作。

早期聽覺測驗

專家已指出 0-3 歲是幼兒發展語言的關鍵時期，對聽覺有問題的幼童，早期語言發音及聽覺訓練是極其重要。如有任何進誤，可能妨礙孩子的語言發展，影響孩子一生的正常學習。

中心也曾幫助一些五歲或六歲的聾童，他們的學習興趣及學習效果遠不及兩、三歲的小孩呢！

為了儘早訓練聾的孩子，中心也專為任何懷疑聽覺有問題的小孩做聽覺測驗（六個月大開始）。凡發現有感音性聽覺問題的小孩，應儘快由聽覺學家介紹配戴合適的耳機，並接受個別的發音及語言訓練。

語言、聽覺、發音訓練

為了更有效地教導聾童唇讀及發音，並訓練他們懂得使用剩餘的少許聽力，每日聾童在家長陪同下，接受個別教導，每節為時四十分鐘。同時中心每星期也有小組活動、韻律操、設計活動，定期舉辦一些户外學習、開心日、夏令營，促進社交發展，培養不同興趣及增廣見聞。

家長輔導

母親在孩子語言學習的過程中佔一個極重要的位置，因母親與孩子關係最密切、相處時間最長、影響孩子最大。如果母親接受此偉大的承擔，積極參予教導孩子的工作，孩子才會有超卓的進展！

另中心兩個月舉行一次母親會及一年舉行四次父親會，使家長能互相分享，交流意見，更認識聾童的一些問題及解決的方法。

混合教育及跟進工作

孩子在接受幼稚園混合教育期間，每天仍需回中心上個別的訓練課程，直至入讀小學後，孩子仍可每星期回來接受一、兩次訓練，直至完全適應小學的學習。

根據中心八年的經驗及一項簡單的調查，發覺混合教育的成功，實在需要多方面的配合，這包括：

一、及早發現，及早診斷。
二、及早接受緊湊、優質素及期望高的特殊訓練（3 歲前便需開始訓練），訓練越早，康復更好！
三、儘早配戴適合的助聽器。
四、每天個別教授以配合每位學生的個別需要。
五、家長陪同孩子上課，家長回家配合訓練，積極教導孩子。
六、必須打好語言基礎，才可進入混合幼稚園及混合幼兒園，以免孩子「讀完幼兒課程」，仍未達到合適的程度進入普通小學。（語言應少於三個月差距）
七、經常有效地評估孩子各方面的進展，若發現孩子某方面有困難時，老師和家長便共同商議，設法改善。
八、得到學校老師的體恤、關心、支持及鼓勵。
九、得到同學的接納及愛心的對待。

如何應用一般教學法和課程、促進特殊兒童的語言發展？

引言

特殊兒童在混合幼稚園或混合幼兒園的課程通常包括下列幾方面：

1）語言發展
2）智能發展
3）體能發展（如肌肉與感官的協調）
4）自我照顧
5）社交適應

一般而言，老師會較側重特殊兒童的智能發展，其實良好的語言發展更為重要。語言基礎好不單可以幫助孩子的情緒穩定和各方面學習能力更好，而且可以促進孩子的智能發展，社交適應及增強自信心。

如何協助孩子的語言發展？

1）平時習慣在日常生活中，把握機會多跟孩子說話，把孩子心中所想的或當時發生的事情描述出來！談話內容盡量環繞孩子有興趣的事物及配合當時的情景。當孩子感到興奮時，便學得更快、語言更有意想不到的的進展！例如：「我地一齊嚟砌積木，一塊一塊叠上去！啊！小心呀！Wow！越嚟越高！小心跌落嚟！好嘢！睇吓！我砌得幾高！——噢！塌咗！（倒塌了！）——唔緊要！我地再砌一次，好嗎？」

2）說話時，大人要投入孩子的世界，帶著豐富的表情和情感，這樣才能吸引孩子的注意力、留心聽你說話。

3）按孩子的語言程度，時時留意把孩子的句子適當地擴張。日子久了，孩子便會說一些較長、較複雜的句子。

例一：小孩：「唔好！」
　　大人：「點解唔好呀？」
例二：小孩：「我地去坐巴士？」
　　大人：「係呀！我地去坐巴士探婆婆。」

4）不可習慣性地要求孩子跟大人說話

假若孩子每次說話都是跟著大人說話，重覆大人所說的一字一句，日子久了，孩子只會成為「跟人說話的機器」，變得像鸚鵡一樣，說話呆板沒有變化，也不懂得思考，所以大人不應操之過急，揠苗助長！

孩子學說話，大人要有信心和耐心，在有意義的情況下，說多幾次。孩子聽了多次，自然便會由明白至吸收，慢慢便會突然自己講出來。例：一天孩子指着窗櫥：「雪糕！」原來孩子已學會了說「雪糕」。

5） 幫助孩子表達自己

當孩子表達自己有困難時，不論是說話不清、或是等了很久仍說不到中心意思時，大人切不可顯得不耐煩，反而應帶著笑容、微微點頭、鼓勵孩子慢慢說。但假若等了好久，孩子仍表達不到自己的意思時，大人便試圖猜孩子心中要表達的意念，給他合適的語言。例：小孩：「哥哥……哥哥……」大人：「做乜嘢呀？係唔係想哥哥請你食？」

6） 讓孩子感到說話有用，而且得到很多樂趣

當孩子感到說話可以幫助他達到目的，孩子便很樂意多說幾次。例如："抱"、"餅餅"、"俾"。同時，當孩子說話時，大人便微笑或拍拍他的肩膊，表示很接納和讚賞的樣子，孩子便會繼續說話、繼續嘗試討人喜歡。

7） 對孩子說話的期望要適中，不可太高或過低。按個別孩子的差異，不同的語言程度便有不同的期望。按孩子的能力循序漸進，不斷逐步加增，直至孩子的語言程度與其他小朋友的語言程度不相伯仲。

8） 養成每天講故事的習慣

小孩二歲起便特別喜歡聽人講故事。如爸爸/媽媽每天都習慣講一些有趣的故事給孩子聽，孩子便不知不覺間吸收了語言的結構、用法及很多新的詞彙、新的句式等。久而久之，孩子便會將一些故事中的語言用自己的說話應用出來。

9） 設計一些扮演遊戲

孩子在二歲至五歲的時候，特別喜歡模做大人。我們可以將學校或家中一些角落佈置成超級市場、餐廳、學校、廚房、客廳、茶樓、公園、百貨公司或巴士站等。
引導孩子扮一些經常可接觸而職業不同的人，例如：扮演父母、醫生、司機、售貨員、理髮師等。進而扮演一些非經常性接觸到的人——消防員、農夫、漁夫等。

10）設計一些有趣的個別和小組活動

做美勞：印樹葉、印手印、做紙偶、做柏燈等。
弄小吃：雞尾小食、烘多士、弄爆谷、做啫喱、包糭子等。
設計活動：浮、沉實驗、計劃及安排生日會、尋寶、鬥快搬積木、障礙賽、猜猜看、變魔術等。

戶外學習：動物園、公園、農場、海洋公園、坐纜車、去街市等。有趣的活動不單可以提高孩子學語言的興趣，更可提高孩子的注意力、創造力、合作性、社交能力及增加生活樂趣。

11）多引導孩子思考

如老師和家長多用啟發性問題引導孩子思考和不太快給予答案，孩子便會漸漸地養成多思考、多發問的習慣，這對語言發展很有幫助。

例：鉛筆鈍了時，可以問孩子要用什麼東西弄尖枝鉛筆。

12）和小孩一起唸歌謠及引發孩子唱歌的興趣

特殊兒童的語言發展是一個日積月累、潛移默化的過程，需要有良好導師（老師和父母）引導，利用良好的語言環境，始能產生顯著的成效，對特殊兒童整體的發展，造成更深遠的影響。

一般教學方法和課程
在混合／特殊幼兒中心之應用

黎程正家

引言

幼兒園的課程在設計的形式上，若能滿足個別兒童的需要，配合幼兒發展的階段，和學習的層次，做循序漸進式的編排，在學習的經驗和目標上，配合幼兒「整個人」，做全面均衡且整體的計劃，則兼收弱能兒童在普通幼兒園中，則不需單獨分開的設計，所謂「個別化」的課程或教學法，故幼兒園的課程應視為一體，教師並不宜因兼收弱能兒童而有不同的教學法或課程。普通幼兒園／幼稚園的課程設計上宜有週密詳細的計劃和安排，但也都能因應不同兒童的能力和興趣，作出彈性的調整。本篇報告的目的是指出普通幼兒園有兼收弱能兒童時，在課室安排、課程設計、教學方法上宜具備那些基本條件，以及應該如何運作，才能在普通幼兒園中達到兼收的目的等。

(1) 普通幼兒園／幼稚園課程的基本條件

a) 課程能配合兒童的發展

一般幼兒園的課程設計若能配合學前兒童的發展階段如配合前運思前(Preoperational Stage)或概念前期(Preconceptual)的特徵和需要，在幼兒在實際的環境中操作，在遊戲或活動中學習，來掌握對事物的概念認識，對發展較慢的幼兒也能在學習的形式上，較易漸進式的學習。

b) 課程能提供幼兒全面均衡發展的機會

幼兒園課程編排，若並非只重視幼兒對讀、寫、算、學術技能的加強或提供，而能在幼兒「整個人」發展的各方面都是提供適當的經驗或活動，如：體能、智能、語言、自我認識／照顧、社交情緒發展方面的活動，則弱能兒童自能較易在較弱的方面得到加強，也能在「正常」的發展方面得到觀察模仿或學習的機會。

c) 課程能滿足個別兒童的需要

幼兒園的課程設計或課室安排運作，能顧及個別兒童的能力、興趣和需要，對於各個不同能力之弱能兒童自能較易適應，也易從普通幼兒園課程安排中得益。

d) 課程能配合兒童的生活經驗、文化、背景

工作員若能了解個別兒童的生活經驗、環境、背景，從而在課程或活動安排上配合，兒童自能較易掌握活動／遊戲所帶出的概念和學習內容。

e) 在遊戲或活動中學習

幼兒園的課室安排，若能盡量以遊戲，或小組活動的方式進行，在教材或活動的形式上能配合不同能力及興趣的兒童，有不同深淺及活動程度的安排，自然滿足兒童之間較大的個別差異，弱能兒童亦較易有較大程度的參予。

f) 有學習評估

幼兒園的一般課程需要具備其本身課程評估的準則，工作員／教師亦需掌握評估個別兒童能力的基本方法，才能在課室安排上，循序漸進，適應各個不同兒童的需要，做出適當的安排。

(2) 兼收的運作——如何利用普通教學法和課程

兼收弱能兒童在幼兒園中，在利用普通教學法和課程時可有如下的安排：

a) 為加強或準備弱能兒童參與一般課室運作，或正常活動的能力，工作員／教師可按其能力，在活動前預先給予基礎訓練或預習教學步驟，增加其吸收及參與正常活動之能力。

例如：兼收組工作員在預知課室工作員在學習角用圖片教導紅色概念時，可事前用不同紅色的物件，讓兒童去觀察分辨，再進而用學習角內即將使用相同圖片，讓弱能兒童去實習等。

b) 正常課室的運作，若是採取分組的形式，兼收工作員可利用實地環境，預先教導弱能兒童在分組時有關之角落規則，活動進行的方式等，或提供機會讓弱能兒童觀察，模仿普通兒童的玩法，引導普通兒童做「小先生」、「大哥哥」或「姊姊」，帶領弱能兒童參與活動。

c) 課室工作員在進行教學活動時，應設計或準備不同深淺程度的教材，能顧及到個別差異的情況，對於各個不同能力的兒童，能給予或提供不同深淺程度，適合兒童個人之學習目標，弱能兒童只是兒童中的一份子，並不需要「分隔」或是「特殊化」處理。

d) 在課室的分組活動中，應顧及到不同能力，不同興趣及不同活動程度的幼兒，故分組活動的內容宜多元化，教材本身具有深淺程序差異及有動有靜的角落設計等，則弱能兒童自然較易參與課室活動或課程之中。

e) 在活動進行的過程中，幼兒教師或工作員可透過觀察或記錄得知兒童參與的情況及學習的表現，如有需要，可做活動後的補足，利用同樣的教材，加強兒童對某些事物概念的認識。

f) 工作員／教師發現弱能兒童在普通課程進行過程中，某方面學習遭遇困難，特殊兒童工作員可與課室工作員商討困難所在，將其學習目標再作分析(Task Analysis)，配合其發展能力及學習內容的深淺程度，另釐訂適合之個別教學目標及學習層次，作更加深入輔導，但其個別學習目標，也宜盡量與幼兒園的普通課程配合，例如：採用相同的單元主題，利用課室的環境佈置，用具，教材等。

g) 若兒童參與正常活動的能力較差，或嚴重影響正常班房運作時，可考慮只參與部份時間，或只進行部份的活動，或有部份時間，教師／工作員在旁輔導，或有部份時間進行個別輔導，或小組訓練等視個別弱能兒童的需要，工作員的時間安排及人手資源調動等。

h) 若弱能兒童因為某些原因，不適合在某些活動時跟自己班內兒童進行分組活動時，例如兒童雖已五歲，某些發展能力僅及兩三歲的幼兒，雖可參與大部份五歲班的活動，但在某些學科活動進行時，可考慮與其能力，及在學習目標相若的組別內進行學習。

i) 一般來說，弱能兒童在一般節日或特別活動，例如：音樂欣賞日，圖工創作日，節令慶祝或大肌肉活動，午飯茶點，睡午覺時間等，可與其他兒童一起，或有工作員在旁輔導，至於其他分組活動時間，例如需要個別輔導或小組訓練，則視個別弱能兒童的需要而定。

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弱智／弱能兒童升讀特殊學校的適應

鄭張婉華

前言

在未入正題前，首先想講個案例，嘉茵5½歲時接受評估，媽媽很心急想知道評估程度去到那裡，之後獲知所派的學校是輕度的，要等一年左右才有位，這只是教育司署的通知，而在特殊學校來講有可能要等上年半或以上，因此媽媽擔心中心在嘉茵滿6歲時便要她出會，在此情況下嘉茵有可能仍未能夠直接轉入小一，便要在家等候派位，因而所受過的訓練會完全忘掉了。對嘉茵來講，她是較為幸運的，因為不到一年特殊學校已通知嘉茵於今年九月入學了。而媽媽內心都有多少矛盾，一方面希望儘早有位入小一，另方面又希望多留中心半年時間，使受訓練更多。

最後嘉茵媽媽明白到嘉茵在中心的訓練已學完，這是時候去到另一階段學習新的知識，所以都很樂意送嘉茵入讀小一。

聽過以上的個案，相信每位家長都會有同感，各位都會對自己的子女升讀小一的適應都有所憂慮，因為子女在會起碼已有3年的時間，對會的環境及教導方法都習慣了，入小一後便180°的轉變過來。無論於子女或家長同時亦都要面對新環境的適應。

講到兒童要適應的問題，亦即是家長擔心兒童會面對的問題，在這一節裏我可以詳細舉例：

a) 兒童不適應新學校，因在會的先生對小朋友非常照顧（又抱又呵護備至），有病的有護士姑娘照顧吃藥。到小一情況有所不同，先生與學生比例1對20人，而會的比例是1對6人，由於有比例上的差別，小一學生在受照顧程度上感到稍為減低。
b) 兒童不守紀律——上堂坐不定、到處亂跑、大聲叫、東張西望、打擾其他兒童。
c) 早餐方面——以往返會吃早餐，時間很鬆，一旦入了小一，便要家長預備早餐、水壺及小量食物在小息時吃，有時兒童不肯在家進食早餐，家長便會擔心兒童肚子餓怎辦呢？帶了食物返校，不知道會不會拿出來吃。
d) 吃飯方面——
   i) 通常家長備有水壺、毛巾、及匙羹，所以會擔心兒童會否懂得吃完飯後從書包中取毛巾抹手抹咀及喝水。
   ii) 又會擔心水壺蓋、毛巾、匙羹等物件可能被另一位兒童取走了。
   iii) 飲水時弄濕衣服以致著涼。
   iv) 擔心兒童偏食吃不飽怎辦？有時會吃餸不吃飯，或食飯不食餸等。
e) 如廁——在會有規定時間讓先生帶兒童去洗手間，家長會擔心兒童在有需要時不識／不敢舉手來表示。
f) 上落樓梯——擔心兒童不習慣，容易絆倒。
g) 安全問題——
   i) 校車上沒有安全帶設備，擔心兒童很易碰倒。
   ii) 在校內小息時會不會給較大的學生碰跌。
h) 學習方面——
   很不同——會側重訓練自我照顧（如穿衣、刷牙、洗面）。小一較重學術方面如寫字、認字、畫畫，家長會擔心兒童一下子要學寫字，能否應付得來，又要學習數學的概念，擔心兒童可否追上。

家長可以做甚麼

a) 回應以上種種問題，家長對圍繞兒童所發生的事感到憂慮是正常現象，擔心是必然的。

b) 但明白到兒童在不同階段有不同的學習方式，家長對兒童的期望亦應該提升，希望兒童學習到自我照顧，能夠獨立，無需倚賴別人。

c) 另外，家長應做到心理上的適應，況且學校已有措施協助兒童：

① i) 安全問題——安全帶
校方會安排較大的學生坐於低班學生隔鄰加以照顧，另外亦有褓母及先生同車。

ii) 小息時高低班學生於不同的操場玩，所以亦不用擔心較大的會碰撞小的。

② 吃飯——遇到偏食的／不懂／不肯食的，先生或社工會鍥他們。

③ 飲水——飯後先生會逐一問有誰仍未喝水，沒有喝過的他們會幫忙取水。

④ 學習方面——
校方及先生都會明白及有處理方法。
由於兒童在校學的東西不同，家長亦都要改變在家教導的方法。

由於各家長不甚了解學校的情況，才會產生這許多的問題，而我們怎樣去適應呢？

具體上來說：

1) 可以參觀學校，增加多些了解。

2) 參加家長會，加強家長間聯系，互相交換經驗分享心得。

3) 另外家長亦應與校方先生作緊密的聯絡，從而得知學生在校的學習進度。

總結：

其實家長也不用太擔心子女在校的情況，因為學生本身的適應力很強，很快便會適應學校生活，老師會盡量教導他們學習自我照顧，養成獨立能力。

多謝各位。

弱智／弱能幼兒升讀特殊學校的適應

黃偉倫

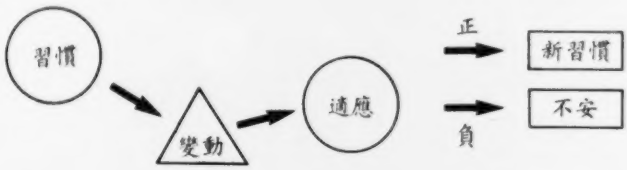
引子

介紹根據中國風俗，父母在幼兒升讀小學時會怎樣做預備。

何謂適應：〔圖片〕

(1)「適」：適合、舒適、善；
「應」：應該、應付、和應。
「適應」：爲求生活舒適，而和應環境之轉變(包括困難)而變化

(2) 改變



(3) 在弱智／弱能幼兒升讀學校時誰人會面對「適應問題」？
弱智／弱能幼兒；父母；兄弟姊妹；特殊幼兒中心導師；特殊學校導師。

弱智／弱能幼兒普遍在升讀特殊學校時所遇改變及困難：〔圖片〕

(1) 因遇改變或困難而引致的問題：
1. 改變一不同習慣一減低安全感一緊張一(若仍解決不了)一消極逃避(如發脾氣、搖身體、大叫、弄手指、不理會別人…)
2. 缺乏處理不習慣情況的能力或經驗一解決不了所面對的問題一安全感降低一緊張一…
3. 弱智／弱能幼兒需要較多時間及鼓勵，但因多種原故未能滿足一安全感減低一緊張一…
4. 很多弱智／弱能幼兒習慣對新事物抗拒，升讀全陌生的特殊學校加深該情況。

(2) 所面對之改變及困難(未盡錄)：
1. 環境：建築物、課室、坐位(要一行行坐)、陳設、洗手間(層數、位置不同)、來回路線及校車不同…
2. 生活習慣：起牀時間、午睡(學校無午睡安排)、上課形式(幼兒中心一般採用活動教學形式)、轉堂(學校採用以下課鈴聲表示)、學科及程序編排、午飯(大部份學校學生需用膠盒吃飯盒，而學生要用自備水壺)、洗手間(一般學校洗手間遠離班房)、來回路程及所乘坐交通工具、校服、做功課(學校功課會較多)、小息時間(學校小息時間較長，且很多學生在一起。)
3. 人物：導師、同學、老友。
4. 關注與期望(一心理壓力)：父母的期望增加，但關注力却往往因過份有信心以致減低。另一方面，在學校內因老師與學生人手比率增加，幼童所受關注自然減少。

家長在弱智／弱能幼兒升讀特殊學校時所遇改變及困難：

(1) 恐怕子女不能適應學校生活一憂心一緊張
(2) 由於子女被斷定要入讀特殊學校一失去「子女變回正常人」的希望一灰心。
(3) 子女能入讀學校，家長以爲可安心(因兒童可讀至十六歲)一對教導子女的責任放鬆一很易會使兒童的不合適行爲出現，也使父母延遲開始適應過程。
(4) 面對子女已長大，爲子女及夫婦倆的未來感到迷惘一憂心一緊張。
(5) 因忽然失去相熟的舊家長及中心導師一無可傾談的對象一悶一憂心一幻想。
(6) 對新學校職員、環境陌生一恐懼。
(7) 對子女期望增加，但當子女達不到時一緊張。
(8) 由於子女要入讀特殊學校，會受到鄰居、親友的好奇或歧視一壓力增加一緊張。
(9) 其他子女會要求父母多增加對他們的關注，但父母却仍憂心弱智／弱能子女未有足夠能力自理。

其他子女所遇到的改變及困難：

(1) 其他子女會希望父母可多分點時間及精神給他們，但父母很多時仍要繼續付出大部份時間及精神給弱智／弱能子女一失望一不滿。
(2) 父母認爲既然弱智／弱能子女已升讀學校，即代表其能力已較前好，故多會放鬆自己的照顧責任一把責任轉給其他子女(父母會以爲他們可勝任的)。

爲何要做適應：

由上述所提改變及困難，可知兒童在升學時極爲無助，而各家庭均受到不同程度的壓力；事實上，就連提供服務的學前及學校教育機構員工亦會面對適應問題。故此如何協助兒童及家人適應升學轉變是必須正視的。亦無怪美國教育部的學前特殊兒童教育計劃部門在政府於八六年通過民法 99——457 後，即要求團體申請研究如何協助兒童及家人適應升學的改變。

特殊幼兒中心如何協助弱智／弱能兒童及其家人適應：(葵盛中心)〔圖片〕

(1) 透過下列方式增加家人對新環境及新改變的認識：
- 參觀特殊學校、庇護工場等；
- 個別、小組、講座形式介紹香港特殊教育及服務；
- 講解如何適應新改變及應作何預備；
- 講解親子關係，協助父母了解及關注其他子女的需要；
- 鼓勵家長互相支持；鼓勵參加家長組織，以鞏固社交圈子；
- 鼓勵家長及其他子女參加社區活動，以協助擴闊社交圈子；
- 中心與鄰近各特殊學校校長、社工等保持良好關係及聯絡。

(2) 透過下列方式協助弱智／弱能兒童對新環境及新改變適應：
- 在日常活動中，加强常規訓練；
- 處理兒童不合適之行爲及習慣；
- 透過有系統的訓練加强兒童的社交、表達、及接收能力；
- 縮短將近升學兒童的午睡時間；
- 讓兒童嘗試以午餐盒／飯盒裝飯餸及以匙取吃；
- 加强穿衣訓練及如廁訓練，使兒童更能易於獨立；
- 協助家長掌握處理兒童情緒及問題行爲的方法；
- 當確實兒童會就讀之學校後，由中心與學校保持聯絡；並於兒童快要離中心時，把有關兒童的「離中心報告」交與校方；
- 對一些合適就讀普通幼稚園或小學的兒童，中心會聯同家長着意兒童在認知概念方面的教導。

從幼兒中心升讀弱智／弱能特殊學校的適應

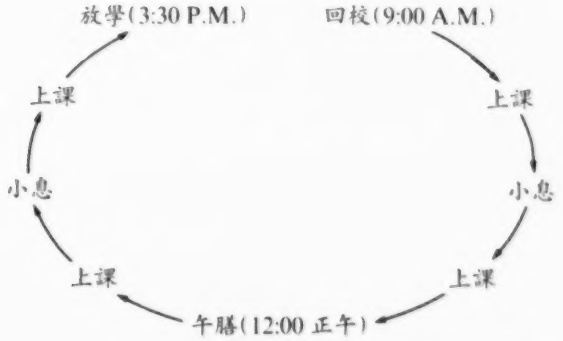
曾志虹

當兒童要從幼兒中心升讀特殊學校時，家長往往是又喜又驚，喜的是孩子可進入另一階段學習，驚的是孩子能否適應呢？以下簡短的介紹特殊學校的課程和孩子常遇到的困難，希望家長閱後，可與孩子一同渡過這一個適應期。

特殊學校的生活程序和課程

香港的特殊學校是爲六歲至十六歲的弱智／弱能兒童提供教育服務，一般弱智特殊學校是設有由小一至中三共十班的，中度弱智學校是十六人一班，而輕度弱智學校是二十人一班的，學校的課程及時間編排是根據弱智兒童的基本需要，並依照他們的年齡、傾向、能力、興趣及程度等個別需要而設計。目的是幫助他們充份發揮個人潛能，促進身心正常發展，培養生活理想和習慣，建立基本能力與謀生技能，使他們能適應社會，自立生活，成爲良好公民。

學校的上課時間是由上午九時至下午三時半，生活程序是很規律化，每天都按照時間表上課，大概如下：



課程是採取單元教學法，揀選的題材盡量是生活化及與兒童生活有直接關係，如「交通工具」、「我的家庭」、「衣服」等。教師多利用實際事例，使兒童感到有切身的關係，引起其學習興趣，故常有課外活動，參觀附近社區設施等。又爲使兒童將所學的應用於日常生活方面，學校多設有小賣部，目的使孩子親身嘗試購買東西整個過程的經驗，如揀選自己喜愛的食物一付錢一找贖等。

學校的課程包括有語文、綜合學科、數學、自理、感知、音樂、美勞、體育、實用技能等訓練。低年級的課程著重溝通、自理、感知、數前概念、基本書寫的訓練。有了上述的基本訓練後，高年級的課程是著重培訓他們在語文及數學上的認知，及教導他們一些實用技能如家政、木工、工作習慣等。

學校的教職員除教師外，亦有社工、言語治療師及心理學家等，嚴重弱智學校亦有護士、物理治療師及職業治療師，各人的職位及工作不同，但都是爲幫助學生能有照顧自己及謀生技能，使他們能適應社會。

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適應期間遇到的困難

孩子在進入特殊學校後是需要一段時間的適應，因兩者在環境設備上，課程內容，生活程序編排，教職員人手比例等都有不同，家長會很擔憂孩子能否適應；而校方亦感到校方在初期確有一些適應困難而盡量作安排協助：

1. 生活程序的編排：幼兒中心多有午睡，而學校是沒有的，故在下午多有興趣小組，及音樂體育等科目來提起他們的興趣。
2. 課程編排：學校的學習科目多了，孩子能否應付得來呢？
   教師編排課程及設計功課時是因人而異，初期多是著重於自理感知訓練，學習聽指示，基本書寫及數學概念。
3. 學生的人數：學校的學生，總比幼兒中心的人數爲多，他們會否被高年級的同學欺負，遊戲時會否被撞倒呢？
   在小息時，學校一定安排足夠人手看管學生，很多的高年級同學都很呵護初入學的小朋友，而孩子本身亦很快學會如何在一大羣人中遊戲。
4. 午膳：初期很多學生會不習慣在學校吃飯，家長亦擔憂他們吃什麼呢？有沒有人照顧他們吃飯？校方會安排足夠人手照顧他們吃飯，如有需要的，更特別安排多些人手照顧。
5. 校車：學校一定會安排一些熟悉學童的成年人或教職員沿途照顧學童，以免發生意外。

總結：

孩子在成長的每一階段都有不同的需要及他們會在生活中學習適應，很多家長亦察覺到他們的子女在進入學校後顯得很高興，每天都嚷着上學、自己拿衣服穿、背書包，這顯示出孩子長大了，故此家長不要常將孩子當作嬰兒看待，不要擔心他們不能適應。再者，家長應與校方合作，無論在孩子的學習上、生活習慣上，盡量做到雙管齊下，孩子會終於學習到照顧自己，適當的社交技巧及基本的謀生技能的。

每一個人都有接受教育的權利，我們的孩子也是，
每一個人的成長階段都不同，我們的孩子也是，
信心、愛心、耐心、時間是每一個與我們的孩子一同成長的人都需要的。

OVERALL IMPRESSION OF SERVICES FOR HANDICAPPED CHILDREN IN HONG KONG

Professor Michael J. Guralnick

1. There is a strong and clear foundation for services to handicapped children in Hong Kong. Most important of all, there is a network and commitment of individuals in many levels within the handicapped community, thus making the continuous growth of services possible in the future years.

2. There is a strong emphasis on developmental approach in many respects, as evidenced in the integration of the handicapped children to a variety of ordinary settings, the curriculum adopted by the Heep Hong Society, and the daily interaction between teachers and children in the various centres that I have visited.

3. There is a willingness to experiment with a whole variety of different approaches, with an attitude of experimentation and creativity even though resources may not allow to.

4. With regard to the issue of training, like the United States, there is a need to provide trained personnel with adequate salary and prestige. In fact there is little commitment of the general community to the most important resources of the society: namely young children and handicapped children, as reflected in the level of support and priority set in service provision. Therefore the public should exert advocacy and pressure to enhance training that already exists in that community.

5. It is necessary to maintain the child in an environment with close contact with typical services as possible, and to involve parents in every level of service system and advocacy system. Meanwhile professionals should continue to build partnership with parents to enhance their decision making capacity and maintain a balanced kind of relationship.

Professor Michael Rutter

1. I am very much impressed by the flexible use of professionals of different disciplines and the effective way they work together e.g. group work done by the Occupational Therapists of the Heep Hong Society in training autistic children.

2. I am also glad to see the involvement of parents in service provisions, something which must have been achieved within a short period of time in Hong Kong.

3. There is a willingness to try out methods of treatment as developed in the United Kingdom.

4. There are a variety of challenges facing the professionals in Hong Kong, such as:
   a) increasing the resources available to autistic children and
   b) integrating services between the clinical side and the educational side as the children grow older.

5. Related to schooling of autistic children, it should be reminded that integration is a means to an end, i.e. to optimize handicapped children's development. Efforts should be made to ensure that handicapped children can integrate as fully as they can.

6. With regard to categorization, problems arise when it is used to label but not to decribe children's needs. Therefore both its strengths and limitations should be considered in planning, monitoring and evaluation of programmes for handicapped children.

7. At present, the focus is on pre-school services. Equal attention should be drawn to the provision of schooling and services for autistic adults as well.

8. Even though specialized services are provided for autistic children, they are usually on a day basis. When autistic children grow older, there is a need for residential services.

9. Much concern should be placed on the transition of handicapped children from school to work and the best way of providing sheltered settings.

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Perth Street Special Education Services Centre of the Education Department

Kathleen MacDouall Day Nursery of St. James' Settlement

Sam Sui Natives Association Lau Pun Cheung School

South Kwai Chung Polyclinic of the Hospital Services Department

PHOTOGRAPHS

Mrs. Agnes Yeung, Chairman of Heep Hong Society at the Press Conference for the Symposium with Professor M.J. Guralnick and Professor M. Rutter.
協康會主席楊羅靚翠女士，M. J. Guralnick教授和M. Rutter教授正爲專題研討會召開記者招待會

Lady Wilson, Professor Guralnick and Professor Rutter at the reception.
總督衛奕信爵士夫人與兩位教授攝於接待茶會中

Lady Wilson, Patron of Heep Hong Society addressing the opening speech at the Opening Ceremony.
協康會贊助人衛奕信爵士夫人在開幕禮時致詞

The guests, speakers and participants are listening attentively at the symposium.
專題研討會場內的嘉賓、講員和參加者正在專心聆聽

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